

0-11155

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 6 1 7 5 8 2

1- STATE REGISTRAR										20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
William F. Addington										X		6/26		19 86	
3. SEX										4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Male										White		Jun. 11, 1911		75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia										U.S.A.		X NEVER MARRIED		Montgomery County	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase										2823 Terrace Drive		Carpenter		Construction	
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland										Montgomery		Chevy Chase		YES X NO	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
James Addington										Irene Ramey		577-28-3559 A		2823 Terrace Drive	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.		17. INFORMANT		2823 Terrace Drive	
No										577-28-3559 A		Julia Addington		Chevy Chase, Md. 20815	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Acute myocardial disease.															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
None															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
None												YES NO X			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
										HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2			
										P.M. 19		None			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
												STREET			
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from:															
Natural causes X Accident Suicide Homicide Undetermined manner															
ACTUAL SIGNATURE										TITLE (SPECIFY)		DATE SIGNED			
John S. Rogers, M.D.										Deputy		6/27/86			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS		1919 Seminary Road		Silver Spring, Montgomery County, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation										6/27/86		Chambers Crematory		Rivendale	
24. FUNERAL DIRECTOR NAME										ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers, Co.										8655 Georgia Ave		JUL 2 1986		Julia Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

0-11468

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 17583

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF ESTI. MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. DATE OF BIRTH		4. AGE (IN YEARS LAST BIRTHDAY)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.	
MAXINE ELLIOT ADLER		May 14, 1912		74 YRS.					
7a. SEX		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Female		USA				Montgomery		Silver Spring	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
806 Islington Street 20910		Secretary		Florist		Maryland		Montgomery	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Harry Burtnick		Daisy Unknown		No		217-44-2886		Hilary W. Costello, Esq.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
PART I DEATH WAS CAUSED BY:		None				YES <input type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
IMMEDIATE CAUSE (a) Acute Myocardial Disease								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION CITY OR TOWN		COUNTY	
		Jun. 6, 1986		Judean Memorial Gardens		Olney, Montgomery, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	
Burial		Jun. 6, 1986		Judean Memorial Gardens		Olney, Montgomery, Maryland			
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. SIGNATURE	
W.W. CHAMBERS CO., 8655 Georgia Ave., S.S. Md. 20910		JUL 7 1986		John S. Rogers, M.D.		Jun. 30, 1986		John S. Rogers, M.D.	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

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00-09781

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 5 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THERESA N. ALBERSTADT			2a. DATE OF DEATH MONTH DAY YEAR June 13, 1986		2b. HOUR 3:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17213 Pinebrook Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY own home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17213 Pinebrook Dr. 20904		
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Catalano				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Consetta Scalco				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Albert Alberstadt-husband-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 months DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) the hospital attended the deceased from May , 19 85 , to June 13 , 19 86 , that (I) last saw the deceased alive on June 13 , 19 86 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) have autopsied (did not) view the body after death.								
22b. SIGNATURE Jules R. Lodish MD				DEGREE MD		22c. DATE SIGNED 6/13/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules Lodish, MD				22e. ADDRESS 2901 Olney Sandy Spring Rd. Olney, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood Pr. Georges Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 18 1986		25b. REGISTRAR'S SIGNATURE Jules Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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END

WINTER



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00-11031

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 5 8 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose M. Allen			2a. DATE OF DEATH MONTH DAY YEAR June 19, 1986		2b. HOUR 1:32 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1 MONTH 28 DAY 30 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 56	7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	10. CITIZEN OF WHAT COUNTRY? U.S.A.	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13. CITY OR TOWN OF DEATH Olney	14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	16. KIND OF BUSINESS OR INDUSTRY Cleaners	
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland	17b. COUNTY Montgomery	17c. CITY OR TOWN Silver Spring	17d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	17e. STREET ADDRESS, ZIP CODE 2410 Brigg Chaney Road Md. 20874	

18. FATHER'S NAME FIRST MIDDLE LAST George R. Reed		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wallace Anderson	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	22. INFORMANT Ann Kitterman	23. ADDRESS 23530 Kings Valley Rd German Md. 20874

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Small Cell Cancer of Lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Chronic Obstructive Lung Disease</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		

22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to JUNE 19, 1986, that (1) (we) last saw the deceased alive on JUNE 18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.

22b. SIGNATURE <i>Jules R. Lodish M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/20/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULES R. LODISH, M.D.		22e. ADDRESS 2901 OLNEY-SANDY SPRING RD, OLNEY, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/21/86	23c. NAME OF CEMETERY OR CREMATORY St. John Church Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.
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24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Inc.	ADDRESS 5655 Georgia Ave Silver Spring Md 20910	25. DATE REC'D. BY REGISTRAR JUN 27 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Smith-Randall</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1931-30

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU
WASHINGTON, D. C.

30% OF

1931-30

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

00-10958

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ronald B. Anderson			2a. DATE OF DEATH MONTH DAY YEAR 6/24/86			2b. HOUR OF DAY 9:50 A.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 11, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury		
13a. STATE Tennessee			13b. COUNTY Sullivan		13c. CITY OR TOWN Bristol		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 128 Amhurst Lane / 37620	
14. FATHER'S NAME FIRST MIDDLE LAST Norris Hays Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ambler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 112-01-5963		17. INFORMANT Mr. Ronald N. Anderson, Son, ADDRESS 898 New Mark Esplanade, Rockville, MD. 20850					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years Approximate Interval Between Onset and Death 2 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia of Alzheimers Type										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from November 18, 1984 to June 24, 1986 , that (we) last saw the deceased alive on June 24, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John F. Gustafson					DEGREE M.D.		22c. DATE SIGNED 6-24-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Gustafson, M.D.					22e. ADDRESS 5480 Wisconsin Ave. Chevy Chase MD 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bristol Tennessee			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD.					25a. DATE REC'D. BY REGISTRAR JUN 30 1986					

MEDICAL CERTIFICATION

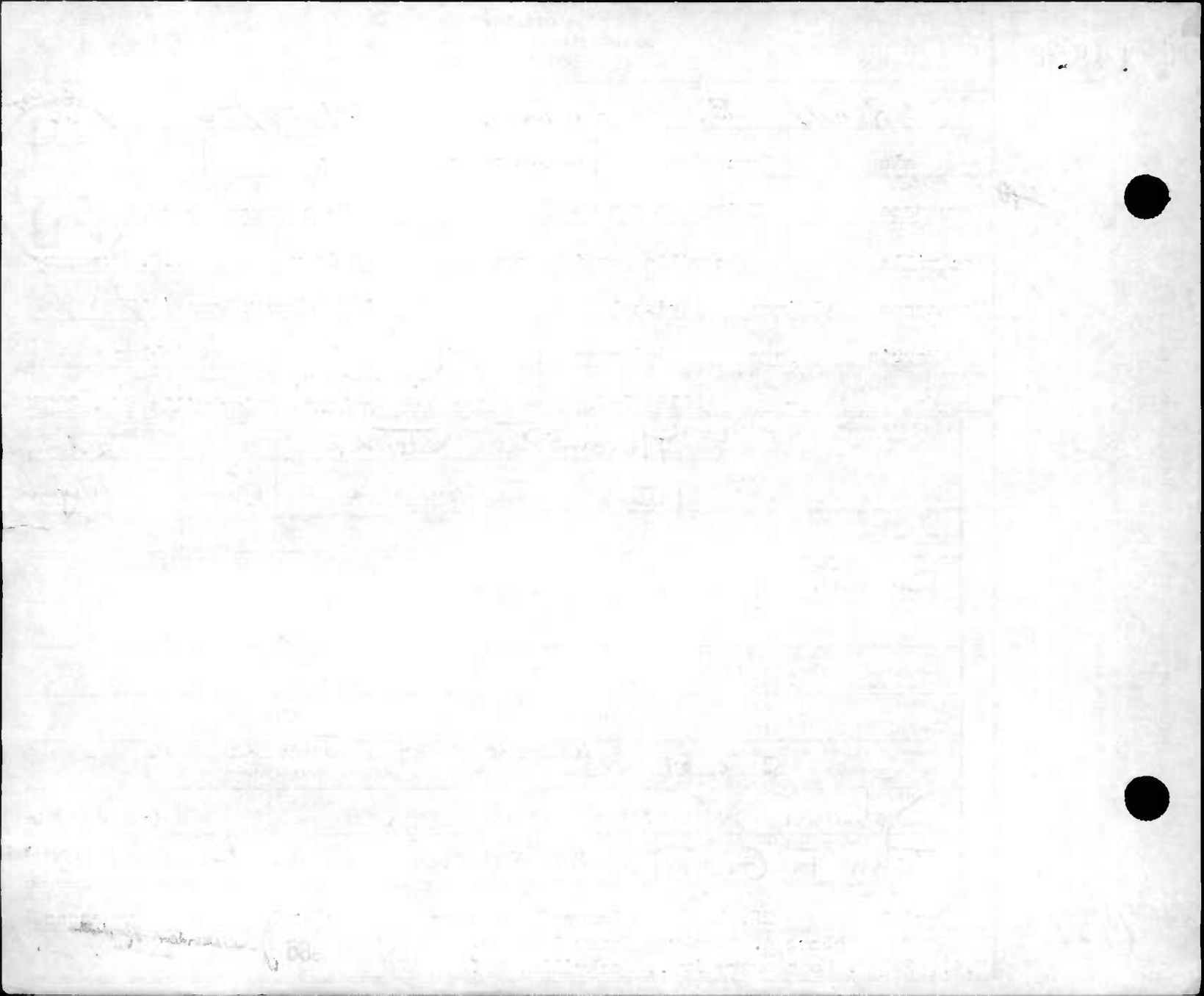
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHWH: 16-50M 1/81
(VRA 15, 4)



00-11159

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Carrie W. Applegate					2a. DATE OF DEATH MONTH June DAY 28 , 1986 18:10 P. HOUR 18:10 M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH Oct. DAY 18 , YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11705 Magruder Lane. 20852	
14. FATHER'S NAME FIRST Sylvester MIDDLE . LAST Titus					15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE UNKNOWN LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 368-68-0622		17. INFORMANT ADDRESS Same as # 13. Phyllis A. Drohat (daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 1 , 19 85 , to June 28 , 19 86 , that (I) (we) last saw the deceased alive on June 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas Sachs M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 6/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Sachs				22e. ADDRESS 2201 L St. N.W. Wash D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE July 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Washtenong Memorial		23d. LOCATION CITY OR TOWN Ann Arbor COUNTY Michigan STATE Michigan			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes PA 300 W. Montgomery Avenue Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR JUL 2 1986 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

02171-0

0-10241

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 7 5 8 8			
1. FOR STATE REGISTRAR		20. DATE OF DEATH								2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		DAY		YEAR	
ROBERT NEIL ARSENAULT								6-17-86		12-50P			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		White		4-30-22		64		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington		USA				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (17. OTHER FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		Chief		Comptroller Acc't System Command							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1400 Castle Boulevard #411				20904	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Paul		Ruth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II		537-26-3635		Elaine L. Arsenault		Wife		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		18 hrs									
Cardiogenic Shock				18 hrs									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		18 hrs									
Cardiac arrest				18 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
Acute Myocardial Infarction													
Severe triple vessel coronary artery disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AT TOP <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>													
AT HOME <input type="checkbox"/>													
22. I certify that (1) this hospital attended the deceased from 6/16 to 6/17, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated													
22a. SIGNATURE		DEGREE		22b. DATE SIGNED									
Alan I. Kernaier, MD		MD		6/17/86									
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS											
ALAN I. KERNAIER, MD		10313 GEORGIA AVE. S.S. MD 20902											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		Jun. 20, 1986		Fort Lincoln Cemetery		Brentwood Prince Georges Md.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Francis J. Collins, Jr.		JUN 23 1986		Julia Davidson-Randall									
500 University Blvd., W. Silver Spring, Md.													

CHARTERED BY THE

1301-2

may be
r. page 3
after death

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BF

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 8 9
REG. NO.

REG. NO.

1 - STATE REGISTRAR		3 - DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6 6 1 7 5 8 9	
CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
DELUA B ATKINS		6/8/86		8:04 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	Black	11-26-34		51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia	USA			Montgomery MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Springs	Hollywood Hospital		Clerk		Telephone Co.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
md		Montgomery		Silver Springs	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
Benjamin		Bowles		1703 Woodman Ave 20902	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		233-58-7349		Robert L. Atkins/1703 Woodman Ave. Slvsprng, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cancer of pancreas				18 mo.	
DUE TO, OR AS A CONSEQUENCE OF (b) Stroke				1 Day	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Anemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
11/84		mass in pancreas		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 6/6/86, 19 86, to 6/8/86, 19 86, that (we) lost (saw the deceased alive on above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Peter Sherer MD				6/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Peter Sherer MD				13947 Ferrara Dr. Wheaton md	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		June/10/1986		Church Cemetery	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Charleston, West		County, Virginia		City or Town	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McGuire Funeral Service, Inc. 7400 Georgia Ave. NW Wash. DC		JUL 11 1986		Julia Davidson-Randall	

00-10959-9

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17590

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Andree P. Baker			2a. DATE OF DEATH MONTH DAY YEAR June 22 1986			2b. HOUR 6:09 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 17 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15311 Pine Orchard Drive #1-G 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Pontonnier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16a. SOCIAL SECURITY NO. 223-30-1880			17. INFORMANT Sister-in-Law			17. ADDRESS Silver Spring, Md. 20906				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Domestic, etiology unknown										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) this hospital attended the deceased from 6/5 19 86 to 6 19 86 that (b) we last saw the deceased alive on 6/5 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) did (did not) view the body after death.										
22b. SIGNATURE Martin C. Shargel MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL M.D.			22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD-20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR JUN 30 1986			25b. REGISTRAR'S SIGNATURE James Gordon-Rodgers				
500 University Blvd., W. Silver Spring, Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

00-10230

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the file for the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6 1 7 5 9 1 REG. NO.		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		June 14, 1986		5:30 am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Female		Black		Mar. 19, 1904		82		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Virginia		USA				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		217 Frederick Avenue		Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		Montg.		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		217 Frederick Ave. 20850	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
James R. Timbers		Martha E. Thompson		No		216-12-4206		Sarah C. King (daughter) same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Transition secondary to</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Hypertensive Cerebrovascular (CVA)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20'</u> <u>6 min</u> <u>1 yr.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCD & angina -</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13/86</u> to <u>6/14/86</u> , that (I) (we) lost the deceased alive on <u>6/13/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>S. N. Jones</u>						<u>6/16/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
				Burial		6-19-86		Norbeck Mem. Park	
				23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
				Olney, Montg. MD		20850			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George R. Snowden		Rockville, MD 20850		<u>Julia Davidson-Rodden</u>					

THE UNIVERSITY OF CHICAGO

BH

0-09598

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SANDRA CORNELL BAKER			2a. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1986		2b. HOUR P 9:10 ^P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 1, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physical Therapist		12b. KIND OF BUSINESS OR INDUSTRY State of Md.
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 642 PARKLAND PLACE 21061
14. FATHER'S NAME FIRST MIDDLE LAST WILBUR W. WEST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED PITT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE	
16b. SOCIAL SECURITY NO 231-56-2581		17. INFORMANT (FATHER) MR. WILBUR WEST		ADDRESS 8 BISHOP DRIVE MONTROSS, VA 22520	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MEDIASTINAL LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 26, 1978, to JUNE 13, 1986, that (I) (we) last saw the deceased alive on JUNE 13, 1986, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE Joseph M. Reilly MD		DEGREE MD		22c. DATE SIGNED 6/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. Reilly		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JUNE 15, 1986	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS, INC.		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALT. MD.
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061		25a. DATE REC'D. BY REGISTRAR JUN 17 1986		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall	

BP

803-0-0

RECEIVED
NOTICE
OF
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00-10346

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6

17593

1. DECEASED NAME (TYPE OR PRINT) LAWRENCE		2. DATE KNOWN OF DEATH ESTIMATED June 19, 1988		2b. HOUR 5:10 P.M.
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Sept 15 60	6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.	7. DATE PRONOUNCED DEAD June 19, 1988
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH D. I. Spgs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13201 Clifton Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mngr. Stationary Store
13a. STATE Monte		13b. CITY OR TOWN D. I. Spgs		13c. STREET ADDRESS 13201 Clifton Rd
14. FATHER'S NAME FIRST MIDDLE LAST Stuart F. Balderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marilyn Carson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 216-82-6769		17. INFORMANT (father) ADDRESS Stuart F. Balderson 17629 McDuff Ave, Olney, Maryland 20832
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Carbon Monoxide DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 6 19 88		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) In car with engine running		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Clifton Rd. D. I. Spgs. Monte Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) D. I. Spgs. MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1919 Seminary Rd., S.S. Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-21-1988		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery Adelphi Pr. Georges Md.
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR JUN 24 1988
25b. REGISTRAR'S SIGNATURE				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17594

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Betty J Barnes			2a. DATE OF DEATH MONTH DAY YEAR 6-18-86			2b. HOUR 1058M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-09-26		6. AGE (IN YEARS LAST BIRTHDAY) 59		
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Spicer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes L. Prevost		13e. STREET ADDRESS / ZIP CODE 11443 Columbia Pike 20904				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 577 30 4486		17. INFORMANT ADDRESS Roger E. Barnes: See #13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF LEFT BREAST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 mos		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) _____		
DUE TO, OR AS A CONSEQUENCE OF						(c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from APRIL 1984 to JUNE 18 1986 , that (I) (we) last saw the deceased alive on JUNE 18 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE James A. Brown, MD				DEGREE MD		22c. DATE SIGNED 6/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				22e. ADDRESS 1480 PHYSICIANS LANE, SUITE 232 ROCKVILLE, MD 20850				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Cana Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Jennings Co, Indiana		
24. FUNERAL DIRECTOR NAME Charles Pearson		ADDRESS Wilson Blvd. VA Arlington, VA		25a. DATE REC'D. BY REGISTRAR JUN 23 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-1-571

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17595

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William E. Barnhart		2a. DATE OF DEATH MONTH DAY YEAR 6 14 86		2b. HOUR 9:30 PM	
3 SEX MALE	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 26 15		6 AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Montgomery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Barnhart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 054-16-1119		17. INFORMANT Daughter	
		ADDRESS College Park, Maryland Ethel B. Jacobs 7513 Sweetbriar Drive 20740			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL CELL CANCER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MONTHS
DUE TO OR AS A CONSEQUENCE OF (b) _____		
DUE TO OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from JAN 1986 to 14 JUNE 1986 , that (I) (we) lost saw the deceased alive on 14 JUNE 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter E. Goetz MD				DEGREE MD	22c. DATE SIGNED 14 JUNE 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 3, 1986	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR JUL 7 1986	
500 University Blvd. West Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Julie Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove containing pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-10836

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17596

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alfredo C. Barrientos				2a. DATE OF DEATH MONTH DAY YEAR 6, 19, 1986 11:48 AM			
3. SEX Male		4. RACE Asian		5. DATE OF BIRTH MONTH DAY YEAR December 1, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines		7b. CITIZEN OF WHAT COUNTRY? Philippines		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Philippine Army	
12b. KIND OF BUSINESS OR INDUSTRY Defense		13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19228 St. Johnsbury Lane 20874		14. FATHER'S NAME FIRST MIDDLE LAST Jose Barrientos			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 577-98-9942		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ramona Cabrera			
16a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Recurrent carcinoma of pancreas with 45 days			
(c) Associated intra abdominal disease & cholangitis or more							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 8/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1/7 , 19 86 , to 6/19 , 19 86 , that (I) (we) last saw the deceased alive on 6/19 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. R. Thistlethwaite		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. Thistlethwaite		22e. ADDRESS 10401 Old Georgetown Rd., Bethesda					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 30 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

4/11/1954

00-08930

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17597

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA BAXT		2a. DATE OF DEATH MONTH DAY YEAR 6 6 86		2b. HOUR 1010 P.M.	
3. SEX F	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 10 15 96		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GR. WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Camp Directress		12b. KIND OF BUSINESS OR INDUSTRY Childrens Camp
13a. STATE Md	13b. COUNTY Montg.	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8004 HAMILTON SPRING RD 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Kaminer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 107-16-8142	17. INFORMANT 8004 Hamilton Spring Road Milton Baxt Bethesda, Md. 20817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 28 19 84 to June 6 19 86 , that (I) (we) last saw the deceased above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Philip Schwanitz		DEGREE PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Schwanitz		22e. ADDRESS 1426 Woodman Ave., Silver Spring, Md. 20902			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 6-9-86	23c. NAME OF CEMETERY OR CREMATORY Beth El Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Paramus New Jersey
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chps. Rockville, Md 20852		25a. DATE REC'D. BY REGISTRAR: JUN 11 1986 25b. REGISTRAR'S SIGNATURE Gina Davidson-Rendall			

2

BH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 9 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (FIRST, MIDDLE, LAST) SAMUEL C. BEAUMONT, JR			2a. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1986		2b. HOUR 11:00^{am}		
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR FEB 9, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
11. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools	
13a. STATE NEW JERSEY		13b. COUNTY Monmouth		13c. CITY OR TOWN Howell Twnship		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel C. Beaumont, Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Kauert		13e. STREET ADDRESS / ZIP CODE Asbury Avenue / 07731			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 156-36-9182		17. INFORMANT Mrs. Lucy Beaumont, Mother,		ADDRESS RD 1, Box 88, Adelphia Rd. Farmingdale, NJ.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Lymphoma (b) Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 6, 1980 to July 23, 1986 , that (I) (we) last saw the deceased alive on June 23, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J GREENBERG				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Ardena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Howell Township, New Jersey	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes,				25a. DATE REC'D. BY REGISTRAR JUN 26 1986			
P.A., 7557 Wisconsin Ave., Bethesda, MD				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20% COLLOID

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-12074

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86 17599	
1- FOR STATE REGISTRAR												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN PAUL BECKER						2a. DATE OF DEATH MONTH DAY YEAR 4-21-86				2b. HOUR 4:23 a.m.			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 21 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS 0				IF UNDER 1 YEAR MONTHS DAYS 0 48			
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GERMANTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JAMES BECKER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERRY WILLIAMS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Terry Williams 18838 Bent Willow Circle, Germantown, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephaly</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not view the body after death.													
22b. SIGNATURE Edward Cornfeld M.D.						22c. DATE SIGNED 4-21-86				DEGREE M.D.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD CORNFELD, M.D.						22e. ADDRESS 10620 Georgia Ave., Silver Spring, MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY MONTGOMERY GENERAL HOSPITAL/ OLNEY, MARYLAND				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS NA													
25a. DATE RECEIVED BY REGISTRAR JUL 1 0 1986												25b. REGISTRAR'S SIGNATURE John S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial or cremation.

BOUND

W-11



1

00-10098

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 17600	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Caroline B. Belser						2a. DATE OF DEATH MONTH DAY YEAR June 17, 1986		2b. HOUR 10:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE ---		13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4201 Butterworth Pl., NW/20016			
14. FATHER'S NAME FIRST MIDDLE LAST Bartow -- Blount				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann C. Gartrell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT 3909 Blackthorn St. Dana Belser, Jr., Chevy Chase, MD 20815							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 5 years 3 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4 19 69 to 6-17 19 86 , that (I) (we) lost saw the deceased alive on 14 JUNE 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James Mackin MO				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED June 18, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. Mackin				22e. ADDRESS 5401 Western Ave, NW, Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, MD					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25a. DATE REC'D BY REGISTRAR JUN 20 1986		25b. REGISTRAR'S SIGNATURE John D. ...					
25c. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016											

00-1002

June 17, 1988

Belser

Caroline

White

Female

Montgomery

Patricia Kesteven Center

Neve Chase

June 18, 1988

3401 Eastern Ave, N.E., Washington, D.C.

James F. Mackin

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617601
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST MORRIS BERGER		2a. DATE OF DEATH MONTH DAY YEAR 6 12 86		2b. HOUR 1:05 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1896	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hill Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Liquor		13a. STREET ADDRESS / ZIP CODE (20902) 1111 University Blvd., W #513	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Israel Berger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWI	
16b. SOCIAL SECURITY NO. 220-32-5341A		17. INFORMANT Anna Berger; Wife; 1111 University Blvd., W #513;		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WROSEPSIS / COLONIC FISTULA DUE TO, OR AS A CONSEQUENCE OF: (b) DELTA CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____	
19a. DATE OF OPERATION 6/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DELTA CANCER		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 15 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) DELTA CANCER	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) SILVER SPRING, MD		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19313 GEORGIA AVE SILVER SPRING, MD 20910	
22a. I certify that (I) (this hospital) attended the deceased from 6/5/86 to 6/12/86 that (I) (we) lost saw the deceased alive on 6/5/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE PENNY L. BISK		22c. DATE SIGNED 6/12/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/15/86		23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Mem. Pk.; Washington, D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR JUN 16 1986		25b. REGISTRAR'S SIGNATURE John T. ...	

MEDICAL CERTIFICATION

00-09554

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessye		FIRST Bessye		MIDDLE		LAST (AKA Small) BERNSTEIN		2a. DATE OF DEATH MONTH DAY YEAR 06 09 86		2b. HOUR 6 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home					
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6121 Montrose Road /20852			
14. FATHER'S NAME FIRST MIDDLE LAST Sol Kolinsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie (Unavailable)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 061-22-5716		17. INFORMANT Leonard Small		ADDRESS 271-33 Grand Central Pkwy. Floral Park, NY 11005					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/9/78 , to 6/9/86 , that (I) (we) last saw the deceased alive on 6/9/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE D.D. Patel				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/10/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL				22e. ADDRESS 6121 MONTROSE RD ROCKVILLE MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 15, 1986				23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cemetery			
23d. LOCATION CITY OR TOWN COUNTY STATE Farmingdale, New York				23e. DATE REC'D. BY REGISTRAR JUN 16 1986				23f. REGISTRAR'S SIGNATURE John Davidson			
24. FUNERAL DIRECTOR NAME Sinai Chapel				ADDRESS Fresh Meadows 162-05 Horace Harding Pkwy., NY 11365							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

[The text in this section is extremely faint and illegible, appearing as light gray smudges and ghosting across the page.]

00-09759

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REC. NO. 17603

1. DECEASED NAME (TYPE OR PRINT) FLOYD ELMORE BEVERLY, SR.			2a. DATE OF DEATH MONTH DAY YEAR JUNE 16 1986		2b. HOUR 1:50 A
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 23 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE VIRGINIA	13b. COUNTY LYNCHBURG	13c. CITY OR TOWN LYNCHBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1420 MONROE STREET 24504	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE HERBERT BEVERLY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CANDICE ANN JORDAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1947-1967	17. INFORMANT ADDRESS ROSA G. BEVERLY, 1420 MONROE STREET, LYNCHBURG, VA 24504			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEVERE CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 11 , 19 86 , to JUNE 16 , 19 86 , that (I) (we) last saw the deceased alive on JUNE 16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S.V. Curiale</i>		22c. DATE SIGNED 16 June 1986		22d. PHYSICIAN'S NAME (PRINT OR TYPE) S.V. CURIALE, LT, MC, USN	
22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814		22f. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/20/86		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN Arlington, Virginia		23e. DATE REC'D. BY REGISTRAR JUN 18 1986			
24. FUNERAL DIRECTOR NAME <i>Shelly Bell</i>		24b. ADDRESS <i>311 71 Patrick St.</i>		24c. REGISTRAR'S SIGNATURE <i>John Jordan</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

10-00735

10-00735

10-00735



10-00735

10-00735

00-10345

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 60M 7/B4
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17604

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence V. Bittner			2a. DATE OF DEATH MONTH DAY YEAR 6 / 20 / 86			2b. HOUR 11:25 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 21 02		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4000 Queen Mary Dr., 20832	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard P. Dougherty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Talbert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATES) N/A		17. INFORMANT John Bittner-Husband-(same as 13e)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from _____, 19 84 , to 20 JUNE 86 , that (I) (we) saw the deceased alive on 16 JUNE 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Thomas E. Dooley, MD		22c. DATE SIGNED 20 June 86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOOLEY, MD					
		22e. ADDRESS 17904 GEORGIA AVE OLNEY, MARYLAND 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR JUN 24 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

93943 110100 200

11/11/11



11-201-0



00-09354

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17605

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		DATE KNOWN OF DEATH		DATE	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR	
Carl W. Blake		6 8 86		1005 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
male	white	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS	HOURS MIN.
		1 7 30	36 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	8. WIDOWED	8. DIVORCED
Vermont	United States	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Hospital	Banker		Investments	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Potomac	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20854	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	17. INFORMANT ADDRESS			
Carroll Wesley Blake	Marion Fair	Dianne L. Blake, same as #13			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?	18b. SOCIAL SECURITY NO.	18c. DATE OF DEATH			
YES (YES, NO, OR UNKNOWN)	1957-1958	002-20-7920			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) coronary arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).					
Hypertension					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED			
John Tamber	Medical Examiner	6-8-86			
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	8218 Wisconsin Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	June 11, 1986	Rock Creek Cemetery	Washington, D.C.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Robert A. Humphrey	JUN 13 1986	John Tamber			
7557 Wisconsin Ave. Bethesda, MD 20814					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

00-00000

WESTERN UNION

200 COTTON 1122B

00-00000

00-11210

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617606
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Frances Lundeen Blitchington</i>			2a. DATE OF DEATH MONTH <i>6</i> DAY <i>24</i> YEAR <i>86</i>			2b. HOUR <i>3:21 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH <i>12</i> DAY <i>28</i> YEAR <i>10</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Silver Spg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Navy Cross Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Prince Georges Adelphi</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>3120 Powder Mill Road 20783</i>		
14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>Monroe</i> LAST <i>Lundeen</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Mamie</i> MIDDLE <i>Mary</i> LAST <i>Carter</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF NOT, GIVE WAR OR DATES) <i>N/A</i>		17. INFORMANT <i>Rosie Adams (sister)</i>		ADDRESS <i>7139 Brown Street Spartanburg, SC</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>decubitus ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic cerebrovascular disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED INJURED <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT INJURED <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 11, 1986</i> to <i>June 24, 1986</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>June 23, 1986</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <i>Walter E. Goetz</i> DEGREE						22c. DATE SIGNED <i>25 June 86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WALTER E. GOOZH MD</i>						22e. ADDRESS <i>2309 SHOREFIELD RD WHEATON MD</i>	

23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>6-28-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenpond Memorial Cemetery</i>		23d. LOCATION <i>Woodruff, South Carolina</i>	
24. FUNERAL DIRECTOR NAME <i>Ives-Pearson FH</i> <i>Arlington, Va. 22201</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Sandom-Rodgers</i>	

DIVISION OF VITAL RECORDS, 201 W. PEESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not injured at work," item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 11 1964" are faintly visible.]

00-09877

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B2
(VRA 15. 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617607

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
E. James Bosco		June 16, 1986		0730	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	1917	68	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, DC		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rockville	SHADY GROVE ADVENTIST HOSP.		Electrician		Union
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9213 Scott Drive 20850	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
Oreste T. Bosco			Tillie Orgle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WWII		578-12-6904 Dorothy J. Bosco Rockville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aortic Aneurysm</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION					
6-15-86					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
Ruptured Abdominal Aortic An					
20a. AUTOPSY?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		7:30 P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 6-15-86 to 6-16-86, that (1) (we) lost saw the deceased alive on 6-16-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Muldaire Silken, MD				6-16-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Muldaire Silken, MD		1811 Prince Philip Dr Olney Md 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		June 18, 1986		Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Robert A. Pumphrey Funeral Homes P.A. 300 W. Montgomery Ave., Rockville, MD		10 10 86			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THELMA C BOURNE			2a. DATE OF DEATH Month 6 Day 15 Year 86			2b. HOUR 2 P. M.					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH May 10, 1906		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
1d. CITY OR TOWN OF DEATH DICKERSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 19230 WASCHE ROAD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY MONTG.		13c. CITY OR TOWN DICKERSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 20753 19230 WASCHE ROAD		
14. FATHER'S NAME First Middle Last IRA WILLIAM			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET SUITOR			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. 219-48-4041	
17. INFORMANT KATHERINE MANN			Address 19230 WASCHE RD DICKERSON, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right C.V.A. - total aphasia DUE TO, OR AS A CONSEQUENCE OF (c) —									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 8 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/28 , 19 84 , to 6/15 , 19 86 , that (I) (was) last saw the deceased alive on 10 June 1986 , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.											
22b. SIGNATURE John J. Fawcett M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c. DATE SIGNED 6/16/86		
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6-18-1986		23c. NAME OF CEMETERY OR CREMATORY MONOCACY			23d. LOCATION (City or Town) (County) (State) BEAUSVILLE MONTG. MD.			
24. FUNERAL DIRECTOR W.C. HILTON						25a. REC'D BY REGISTRAR DATE JUN 20 1986		25b. REGISTRAR'S SIGNATURE Julia Denton-Rodgers			

MEDICAL CERTIFICATION

99

ENTRANCE TO THE CHURCH

00-09924

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 6 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Euelyn E Bower			2a. DATE OF DEATH MONTH DAY YEAR 6-10-86		2b. HOUR MIN. 4:45 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-14-38		6. AGE (IN YEARS LAST BIRTHDAY) 48
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTG.		13c. CITY OR TOWN BOYDS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN L BURDETTE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET EINWACHTER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO		17. SOCIAL SECURITY NO. 218-34-6312
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hepatic and renal failure DUE TO, OR AS A CONSEQUENCE OF (c) ovarian cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 3 weeks 3 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/20 19 86 to 6/10 19 86 that (I) (we) lost saw the deceased alive on 6/9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bruce A. Silver, MD				DEGREE MD		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER, M.D.				22e. ADDRESS 106 Irving St., NW, #44, Wash, D.C. 20010		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-12-86		23c. NAME OF CEMETERY OR CREMATORY BOYDS PRESBYTERIAN		23d. LOCATION CITY OR TOWN COUNTY STATE BOYDS MONTG MD
24. FUNERAL DIRECTOR NAME W.C. HILTON		ADDRESS 22111 BEALLSVILLE RD BARNESVILLE, MD.		25a. DATE RECD. BY REGISTRAR JUN 16 1986		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

NEW YORK

NEW YORK

0-09072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72601 of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 1 0
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST MARGARET Gramm BOWMAN		2a. DATE OF DEATH MONTH DAY YEAR 6 7 86		2b. HOUR 3:47 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 15 10		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE New Jersey		13b. COUNTY Ocean		13c. CITY OR TOWN Whiting		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Parke N. Gramm		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Cooper		13e. STREET ADDRESS / ZIP CODE 8 Cranston Court / 08759			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Mr. Floyd S. Bowman, Husband, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>1985</u> , to <u>JUNE 17</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>C. Linwood Gold</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/18/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Linwood Gold, M.D.				22e. ADDRESS 8630 Fenton Street Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1986 June 12,		23c. NAME OF CEMETERY OR CREMATORY Seaman's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Savona New York	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 10 1986		25b. REGISTRAR'S SIGNATURE <u>June Davidson</u>	

100-10000

MADE IN U.S.A. 100-10000

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MADE IN U.S.A. 100-10000

00-09880

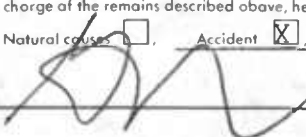

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Joseph		MIDDLE N.		LAST Brewer, III		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6/ 17/ 19 86		2b. HOUR M A	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1966	6. AGE (IN YEARS) (LAST BIRTHDAY) 20 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6/ 17/ 19 86		2d. HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Automobile			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 18700 Rocky Way		20855	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Brewer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Andrea Auth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-72-2669		17. INFORMANT Father William F. Brewer				ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8152 IMMEDIATE CAUSE (a). Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:10AM 6/17/19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject motorcyclist/fixed object impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Conneticut Ave., Silver Spring, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 6/17/86			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland			
24. FUNERAL DIRECTOR'S NAME Robert A. Humphrey				ADDRESS Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 19 1986		25b. REGISTRAR'S SIGNATURE 	

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

38944-00

2025 COTTON FIBER

00-09726

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

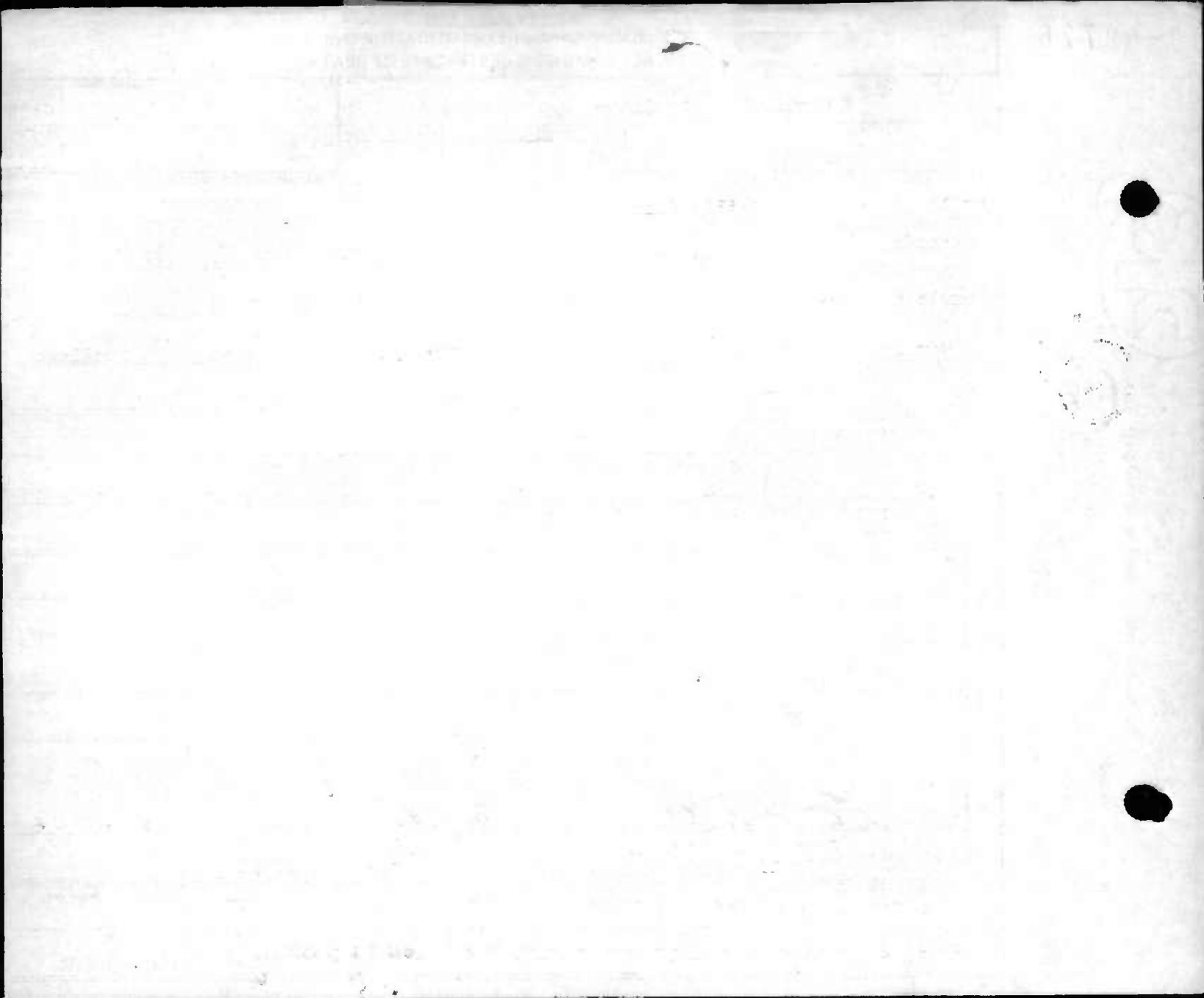
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7612	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Carlos Arellano Bruce										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 06-04 1986	
3. SEX Male										2b. HOUR 4:00 PM	
4. RACE Filipino										2c. DATE PRONOUNCED DEAD 06-04 1986	
5. DATE OF BIRTH MONTH DAY YEAR 02 15 55										2d. HOUR 4:45	
6. AGE (IN YEARS) (LAST BIRTHDAY) 31 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines										7b. CITIZEN OF WHAT COUNTRY? Philippines	
7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Naval Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Navy										12b. KIND OF BUSINESS OR INDUSTRY Defense	
13a. STATE Maryland										13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS NMC, NCR BEQ 60										20814	
14. FATHER'S NAME FIRST MIDDLE LAST Fermin Alvarez Bruce										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelita Asahan Arellano	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. 1983-present	
17. INFORMANT Morgan Burns, Casualty Officer											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HANGING DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John F. Tauber, M.D.										TITLE (SPECIFY) Medical Examiner	
EXAMINER'S NAME (TYPE OR PRINT) John F. Tauber, M.D., 8212 Wisconsin Avenue										DATE SIGNED 6-6-86	
ADDRESS Bethesda, MD 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 6/ 11/86	
23c. NAME OF CEMETERY OR CREMATORY GLODENGATE NATIONAL										23d. LOCATION CITY OR TOWN SAN BRUNO, COUNTY CALIF	
24. FUNERAL DIRECTOR NAME ADDRESS MARSHALL'S FUNERAL HOME 4217 9TH ST. N.W. WASH, D.C.										25a. DATE REC'D. BY REGISTRAR JUN 16 1986	
										25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION



00-09795

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17613
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lillian M. BUELL</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>6-13-86</u>		2b. HOUR <u>2:40</u> ^P	
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7-27-08</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>C & P Telephone Company</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Leonberger</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret Kidwell</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>			16b. SOCIAL SECURITY NO. <u>577-01-2324</u>		17. INFORMANT <u>Niece</u> <u>Rose Axon</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Non-Hodgkin's Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic heart disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>86</u> , to <u>6/13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <u>G. Lennard Gold, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/14/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. Lennard Gold, M.D.</u>				22e. ADDRESS <u>8630 Fenton Street, Silver Spring, Md. 20910</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 17, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Pr. Geo., Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u> <u>500 University Blvd., W. Silver Spring, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1986</u>		
				25b. REGISTRAR'S SIGNATURE <u>Julia K. ...</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must examine the body.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and it will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 1 4
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
1. MARY CATHERINE BUETTNER				8 5 YRS		IF UNDER 24 HRS	
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH DAY YEAR	
FEMALE		WHITE		11 9 1900			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WASHINGTON DC		USA				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		10104 RENFREW ROAD 20901		CLERICAL		US GOVERNMENT	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
CHARLES MAGNUS KHUEN		MARY CATHERINE FRAWLEY		10104 RENFREW ROAD 20901			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT		ADDRESS	
No		N/A		J.C. HARGRAVES (SON)		SAME as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident							
DUE TO, OR AS A CONSEQUENCE OF							
(b) ARTERIOSCLEROTIC VASCULAR DISEASE							
DUE TO, OR AS A CONSEQUENCE OF							
(c) GENERALIZED ARTERIOSCLEROSIS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 17 19 86 to JUNE 8 19 86, that (we) last saw the deceased alive on JUNE 8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Bernard A. Fitzgerald MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-8-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
BERNARD A. FITZGERALD				217 UNIVERSITY BLVD EAST, SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		June 11, 86		Arlington Nat'l Cemetery Arlington, Virginia		CITY OR TOWN COUNTY STATE	
						20901	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins, Jr.				JUN 11 1986		Julia Davidson-Randall	
500 University Blvd. West Silver Spring, Md.							

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00-08898

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 7 6 1 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM W. BURDETTE			2a. DATE OF DEATH MONTH DAY YEAR JUNE 5, 1986		2b. HOUR 9:30 A M		
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 6, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BOYDS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 19735 WHITE GROUND ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. MONT. BOYDS				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19735 WHITE GROUND ROAD 20841	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN D. BURDETTE				15. MOTHER'S MAIDEN NAME MIDDLE LAST MAGGIE KING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-0499		17. INFORMANT ADDRESS JOYCE DAVIS UNION BRIDGE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LUNG WITH CEREBRAL METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DIABETES							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/6 , 19 86 , to 6/5 , 19 86 , that (I) (we) last saw the deceased alive on 5/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard Katon</i> M.D. 22c. DATE SIGNED 6/5/86						22d. ADDRESS GERMANTOWN, MD. 20874	
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL		23b. DATE JUNE 9, 1986		23c. NAME OF CEMETERY OR CREMATORY BOYDS CEMETERY		23d. LOCATION (SEE INSTRUCTIONS) BOYDS MONT. MD. STATE	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR JUN 9 1986 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

BP

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100% COTTON FIBRE

WINDMILL



00-09139

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17616
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Howard Burke			2a. DATE OF DEATH MONTH DAY YEAR 06 09 86		2b. HOUR 2:22 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 28, 1918		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk/ U.S. Naval Hospital		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3302 Jones Bridge Road / 20815	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Cleveland Burke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy May Creel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT ADDRESS Katherine L. Burke, Wife, Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>		<u>days</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Osteomyelitis</u>		<u>days</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Prostatic milt - Cerebro-vascular Accident</u>			
19a. DATE OF OPERATION <u>8/10/86</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/6/86</u> 19 <u>86</u> , to <u>8/8</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Joe Schallma</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>8/9/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joe Schallma MD</u>		22e. ADDRESS <u>9410 Old Georgetown Rd Bethesda</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 11, 1986	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD.		25a. DATE REC'D. BY REGISTRAR JUN 11 1986	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-0-136



00-0-136

00-0-136

00-0-136

00-08880

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17617

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALFRED C BURNS			6-2-86			610 P				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Webster Burns			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace C. Sheckels			13e. STREET ADDRESS / ZIP CODE 12819 Epping Terr. 20906				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 217-14-7763		17. INFORMANT Laura L. Burns,		ADDRESS Item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary Perforated Sphincter DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Barium Poison										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (his hospital) attended the deceased from 5/25/86 19 86 to 6/2 19 86 , that (I) (we) last saw the deceased alive on 6/2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Doc Schuman				22e. ADDRESS 9410 Old George Run Rd Bethesda						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.				
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.,				ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR JUN 9 1986			25b. REGISTRAR'S SIGNATURE [Signature]	

1911-1912

White

Dec. 13, 1909

to

Veryland

Veryland

1811

Veryland

Green

Green

217-11-700

1811

00-09794

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE E BURNS			2a. DATE OF DEATH MONTH DAY YEAR 6/15/1986			2b. HOUR 6:15 A.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06 04 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 16421 Lea Drive 20716		
14. FATHER'S NAME FIRST MIDDLE LAST John Edwards		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Davies		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Daughter Margaret E. Gabel 13523 Vandalia Drive 20853	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ RECORD CAUSE: Renal Failure Constrictive Heart Failure Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years Years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from May 19 81 to June 15 19 86 that (I/we) last saw the deceased alive on above, (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 June 86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibovitch		22e. ADDRESS 11120 Maple St, Apt 20904								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1986		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince George's Md.				
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd, West Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED

NOV 20 1960

NOV 20 1960

NOV 20 1960



00-09068

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the health officer within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 1 9

REG. NO.

1 - FOR
STATE
REGISTRAR

ROGER

B.

BURRISS

1 DECEASED NAME
(TYPE OR PRINT)

Roger

FIRST MIDDLE

B

LAST

Burris

2a DATE OF DEATH

6 8 86

2b HOUR

08⁰³ AM

3 SEX

MALE

4 RACE

WHITE

5 DATE OF BIRTH

JAN. 17, 1908

6 AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

MD.

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10 CITY OR TOWN OF DEATH

ROCKVILLE

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist

12a USUAL OCCUPATION

(IF DECEASED WAS WORKING FOR LIFE)
SERVICE ADV.

12b KIND OF BUSINESS OR INDUSTRY

AUTO DEALER

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b STATE

MD.

13c COUNTY

MONT.

13d CITY OR TOWN

GAITHERSBURG

13e INSIDE CITY LIMITS?

YES ☒ NO ☐

13f STREET ADDRESS

727 REGENT COURT

20878

14 FATHER'S NAME

Thomas

MIDDLE

-

15 MOTHER'S MAIDEN NAME

Mary

MIDDLE

-

16 LAST

Gray

16a DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

YES, NO OR UNKNOWN

16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

579-03-9229

17 INFORMANT

ADDRESS

ROBIN B. CROCKETT

SAME AS #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Artery, complete heart block

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hr

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

1 hr

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes, congestive heart failure

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 4 19 86, to 6 8 19 86, that (I) (we) lost
saw the deceased alive on 6 8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

D. J. Friedman

DEGREE

MD

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c DATE SIGNED

6/8/86

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Dennis Friedman

22e ADDRESS

13-15 E Deer Park, Cambridge MD

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b DATE

JUNE 10, 1986

23c NAME OF CEMETERY OR CREMATORY

MT. CARMEL

23d LOCATION

SUNSHINE

MONT.

MD. STATE

24 FUNERAL DIRECTOR

FRANCIS H. BARBER

LAYTONSVILLE, MD.

20879

25a DATE REC'D. BY REGISTRAR

JUN 10 1986

25b REGISTRAR'S SIGNATURE

John Davidson

0-10000



100% COTTON

100% COTTON



MADE IN U.S.A. 100% COTTON

00-09141

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17620
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl E. Bush			2a. DATE OF DEATH MONTH DAY YEAR 6 8 86		2b. HOUR M 6:52A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2 11 16	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Logistician	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Army	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter E. Bush		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Jarrett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WWII 705-16-0443	17. INFORMANT ADDRESS Mrs. Marguerite G. Bush, Wife, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, chronic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Liver Failure - Hepatitis?					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-20 , 19 86 , to 6-8 , 19 86 , that (I) (we) lost saw the deceased alive on 6-7-86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alberto Rotsztain	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto Rotsztain, M.D.		22e. ADDRESS 10401 old georgetown Rd #254 Bethesda, Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE June 10, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		FURNAL HOMES, ADDRESS P.A., 300 W. Montgomery Ave., Rockville, MD.		25a. DATE REC'D. BY REGISTRAR JUN 11 1986	25b. REGISTRAR'S SIGNATURE J. Davidson

17100-01



000 17100

00-08776

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 2 1
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (Last, first, middle) Mary Katherine Bussard			2a. DATE OF DEATH MONTH DAY YEAR 6/1/86		2b. HOUR 11:00 am
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9/16/96		6. AGE (IN YEARS, LAST BIRTHDAY) 89	7. UNDER 1 YEAR MONTHS DAYS YRS
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12. CITY OR TOWN OF DEATH Olney		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. MAKER	15. KIND OF BUSINESS OR INDUSTRY HOME
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD 16b. COUNTY Montgomery 16c. CITY OR TOWN Derwood		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 18015 Muncaster Rd. 20855	
19. FATHER'S NAME FIRST MIDDLE LAST URIAH G. LAWSON		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA - HOLLAND			
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		22. SOCIAL SECURITY NO. 213-24-2773		23. INFORMANT ADDRESS JAMES E. BUSSARD S AME AS # 13 ST.	
24. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 15 mm years (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 6/1 86		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE 18111 Pr Philip Dr, Olney MD 20855	
35. I certify that (1) (this hospital) attended the deceased from 5/28 to 6/1 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. above, (1) (we) (did) (not) view the body after death.					
36. SIGNATURE [Signature]		DEGREE [Signature]		37. DATE SIGNED 6/1/86	
38. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. [Signature]		39. ADDRESS 18111 Pr Philip Dr, Olney MD 20855			
40. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		41. DATE JUNE 5, 1986		42. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
43. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20879		44. LOCATION CITY OR TOWN COUNTY STATE FREDERICK FREDERICK MD.		45. DATE REC'D. BY REGISTRAR 46. REGISTRAR'S SIGNATURE JUN 6 1986 [Signature]	

00-01553

RECEIVED
NOTICE
NOV 20 1963

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(14)

14 SEP 1963

00-09655

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

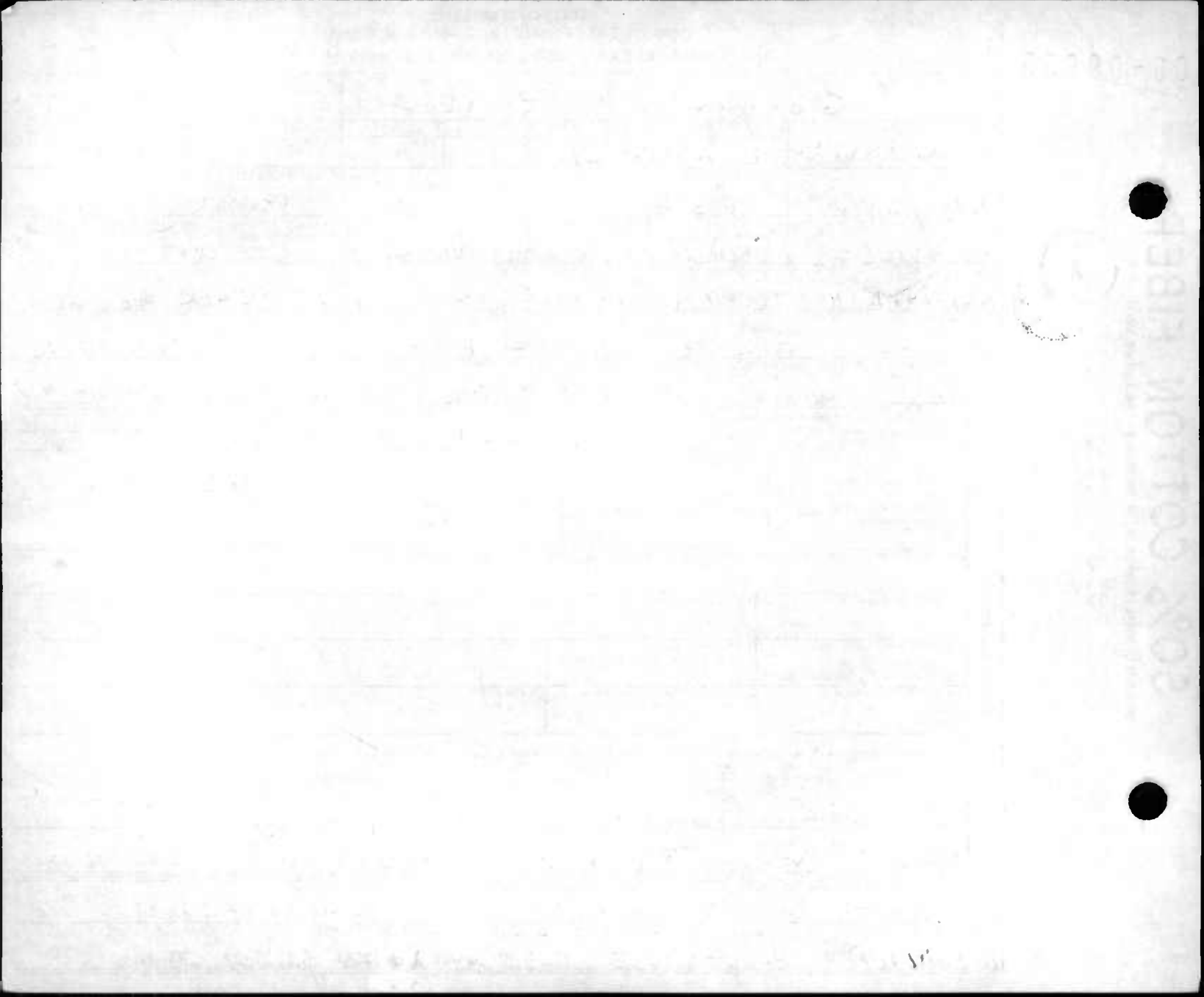
FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Gorman		MIDDLE		LAST Butler		2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 6 1986		2c. HOUR 72c	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 27 18		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 1986		2d. HOUR 72c	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LT. POLICE DEPT. MONTG. CO. P.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POOLESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19525 FISHER AVE - 20887			
14. FATHER'S NAME FIRST MIDDLE LAST GORMAN JOSEPH BUTLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH SNODUFFER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. U.W.I.		17. INFORMANT 578-20-3585		ADDRESS RONALD L. BUTLER, COLUMBIA, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 6-6-86			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8618 Wisconsin Ave Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-9-86		23c. NAME OF CEMETERY OR CREMATORY MONOCACY		23d. LOCATION CITY OR TOWN COUNTY STATE BEALLSVILLE MONTG MD					
24. FUNERAL DIRECTOR NAME W.C. HILTON				ADDRESS 2211 BEALLSVILLE RD. BARNESVILLE, MD		25a. DATE REC'D. BY REGISTRAR JUN 12 1986		25b. REGISTRAR'S SIGNATURE John Tauber			

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 2 3
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Francis F Cady			2a. DATE OF DEATH MONTH DAY YEAR 6/28/86		2b. HOUR 3 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 27 16	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collector - Monetco Vending		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Paul Cady		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Sophie Annie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 579-14-6056		17. INFORMANT ADDRESS Rebecca M. Cady Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Alzheimers disease DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 year. 7 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 16, 1986, to June 28, 1986, that (I) (we) last saw the deceased alive on June 23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE 		DEGREE MD		22c. DATE SIGNED 6-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.		22e. ADDRESS 207 Brooker Ave Gaithersburg Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 2, 1986	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR JUL 7 1986		25b. REGISTRAR'S SIGNATURE 	
500 University Blvd. West Silver Spring, Md.					

Handwritten text, possibly a title or header, including the word "TAK" and other illegible characters.

Main body of handwritten text, consisting of several lines of cursive script.

1

X

Bottom section of handwritten text, including a signature and possibly a date.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by M.E. Dr. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-11564

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 7 6 2 4	
1- FOR STATE REGISTRAR		7- REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JOHN CALDO					2a. DATE OF DEATH MONTH DAY YEAR JUNE 28 1986			2b. HOUR 2:20 A			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 24 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4705 GLASGOW DRIVE 20853			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS LESLIE CALDO					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ANN RILEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1967		17. INFORMANT WIFE		ADDRESS 20853 ROSE A. CALDO, 4705 GLASGOW DRIVE, ROCKVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION 27 JUNE 1986			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from JUNE 27, 1986, to JUNE 28, 1986, that (I) (we) last saw the deceased alive on JUNE 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (not) view the body after death.											
22b. SIGNATURE J. P. Rice					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 30 June 86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. RICE, LT, MC, USNR					22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR JUL 7 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

00-1126

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17625
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ERNEST A. CAPELLE			2a. DATE OF DEATH MONTH DAY YEAR 6-27-86		2b. HOUR 3:30 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 4, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15300 Barningham Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 15300 Barningham Court 20906
14. FATHER'S NAME FIRST MIDDLE LAST Ernest A. Capelle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Burger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 104-09-0420		17. INFORMANT ADDRESS Margaret Capelle Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 6-18-86 19 73 , to 6-27 19 86 , that (1) (we) lost saw the deceased alive on 6-18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto Rotsztain, M.D.		22e. ADDRESS 3701 Rossmoor Blvd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 30, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR JUL '7 1986	25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-00770

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17026

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Philomena G. Capozzi			2a. DATE OF DEATH MONTH DAY YEAR June 2 1986		2b. HOUR 4:15 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 1 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 199 Rollins Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Operator		12b. KIND OF BUSINESS OR INDUSTRY City Govt.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 199 Rollins Ave./20852	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph DiZillo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Felice		16. SOCIAL SECURITY NO. 113-05-4293				17. INFORMANT ADDRESS Armand A. Capozzi 199 Rollins Ave., Apt. 613 Rockville, Maryland 20852	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 113-05-4293		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 8 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-30-86 to 6-2-86 , that (I) (we) last saw the deceased alive on 5-30-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If certified and not view the body after death.)								22c. DATE SIGNED 6-2-86	
22b. SIGNATURE JOEL A. REISKIN, MD		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-2-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. REISKIN, MD		22e. ADDRESS 58 W. EDMONSTON DRIVE ROCKVILLE, MD 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS 300 West Montgomery Ave., Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR JUN 6 1986		25b. REGISTRAR'S SIGNATURE Jana Davidson			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is any injury or other traumatic event, the medical examiner must be notified.

20% COTTON FIBER

112

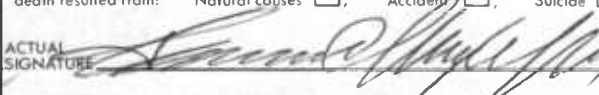

1170

625-111-5101
C. H. WILSON

00-1099

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17621

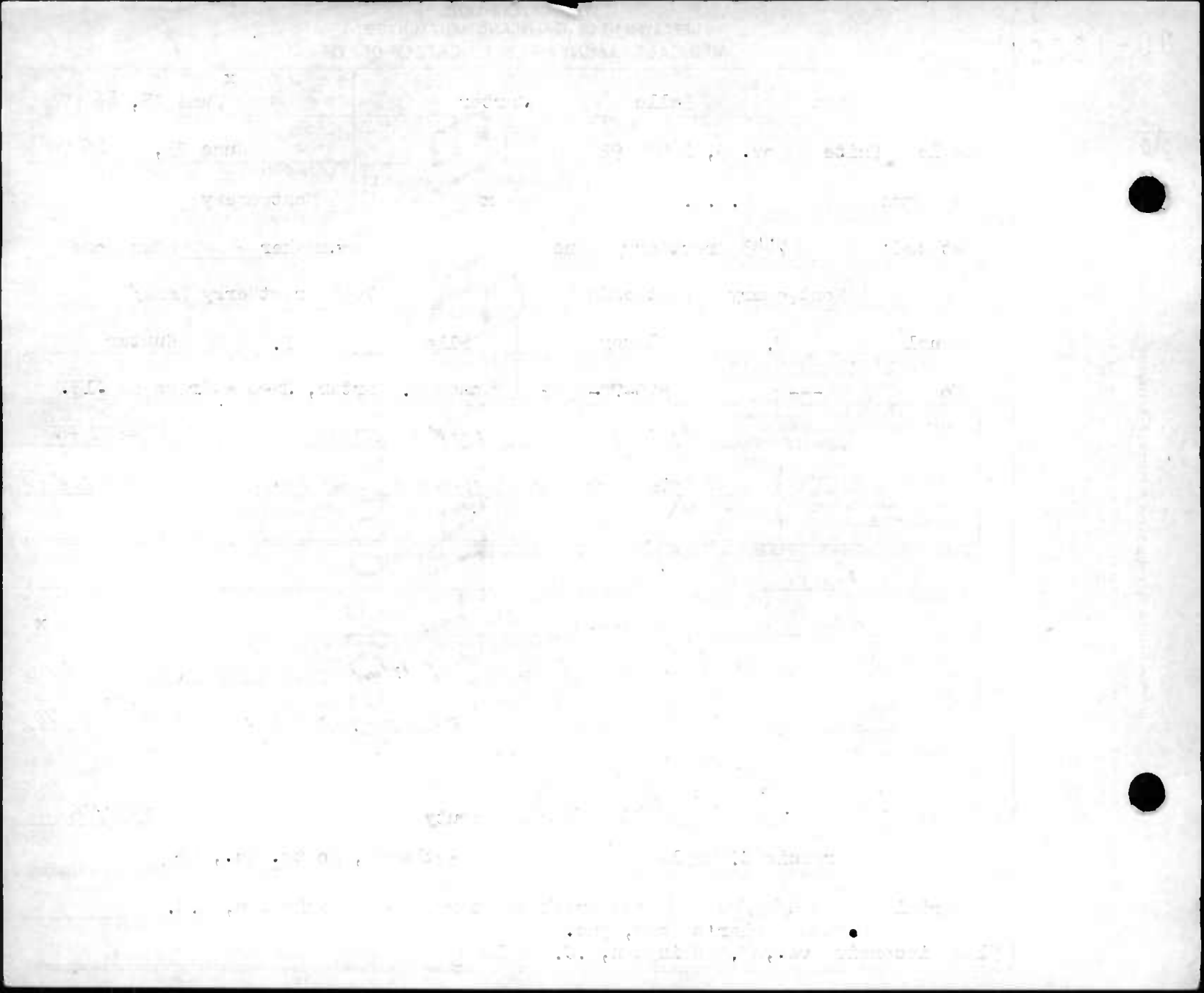
1. DECEASED NAME (TYPE OR PRINT) Anna Belle Carter			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR June 23, 1986			2b. HOUR 7A M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1893	6. AGE (IN YEARS) LAST BIRTHDAY 92 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD June 23, 1986			2d. HOUR 7A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7443 Crestberry Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7443 Crestberry Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel W. Clokey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella I. Hunter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-70-9982		17. INFORMANT ADDRESS Thomas N. Carter, Same address as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) INDEF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fractured Rt Hip									
19a. DATE OF OPERATION 4-12-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fractured Rt Hip					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR AM P.M. 4 11 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL AT HOME - FOUND DEAD IN BED					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7443 CRESTBERRY LANE BETHESDA MONTG. MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 6/23/86			
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle		ADDRESS Bethesda, Montg. Co., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/86		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR JUN 26 1986		25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME)
30M 7/73

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD, 21201



00-11825

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17628

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE P. CARTER			2a. DATE OF DEATH MONTH DAY YEAR June 29, 1986			2b. HOUR M			
3 SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 09 25 00		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS TYRONE W. PRYOR, GLENDALE, MD. 20709				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY ON ITEM 18, PART I, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6116 Robinwood, Bethesda 20817				
22a. I certify that (I) (this hospital) attended the deceased from Nov 1985 to date , that (I) (we) last saw the deceased alive on 6/29/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death, so state.)									
22b. SIGNATURE Thos G. Ward						22c. DATE SIGNED 6/30/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward						22e. ADDRESS 6116 Robinwood, Bethesda 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/7/86		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG. Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers, Co						25a. DATE REC'D. BY REGISTRAR JUL 09 1986		25b. REGISTRAR'S SIGNATURE John William Chambers	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-10734

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 2 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Josephine Charlotte</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>06 22 86</u>			2b. HOUR <u>752</u> P.M.			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>June 20, 1917</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Louisiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Jack Ebon</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>454-22-5446</u>		17. INFORMANT ADDRESS <u>Louie E. Carter same as 13e</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC IMMOBILITY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DEPRESSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DEHYDRATION + MALNUTRITION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/21</u> , 19 <u>86</u> , to <u>6/22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alan S. Chanales</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6/22/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALAN S. CHANALES</u>				22e. ADDRESS <u>9410 020 GEORGETOWN RD BETHERDA MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>6/23/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION <u>Suitland, Maryland</u> STATE			
24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> ADDRESS <u>1331 Rockville Pike, Rockville, Maryland 20852</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 27 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Juan Hernandez</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10

00-10970

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17630

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST	
EDWIN A CHAMBERS			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
M	B	4 14 40	46 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
WASH. DC	U.S.A.		MONTGOMERY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	HARY GROVE ADVENTIST HSP		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MD	Montgomery	Rockville	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.	
Alonzo	Chambers	578-526932	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	
YES	Army	IREATHA PRATHER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:		ACUTE	
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		INDEF	
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	0455 P.M. 6 10 19 86	ARRESTED IN BED	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION	
	Home	703 Lenmore Ave Rockville Mont. MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Francis C. Myle		M.D. Dpt	
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER	
Francis C. Myle		DATE SIGNED 6/10/86	
ADDRESS		20815	
8200 Wisconsin Ave Bethesda MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
BURIAL	6-14-86	Emory Grove Cem.	Gaithersburg Mont. MD
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
George R Snowden	JUN 14 1986		Julia Davidson-Randall

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



RECEIVED
JUL 10 1964
U.S. AIR FORCE

RECEIVED
JUL 10 1964
U.S. AIR FORCE

0-10281

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Olive M. Chambers			2a. DATE OF DEATH MONTH DAY YEAR 6-16-1986			2b. HOUR 940 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 5 1988		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Parkton, md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring, md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pac HealthCare Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 56 B Fenway South/ 21221		14. FATHER'S NAME FIRST MIDDLE LAST Alexander Weekly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa (unk.)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Betty Lou Boyle, 14115 Weeping Willow Dr., #23, Wheaton, MD 20906			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carotidemia of Colon

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 mos

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/16 1986 to 6/16 1986, that (I) (we) last saw the deceased alive on 6/16 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE K. I. Benack MD				DEGREE MD		22c. DATE SIGNED 6/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 4115 Nolie Dr. Wheaton, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkton, Balto., MD	
24. FUNERAL DIRECTOR NAME J. J. Hantenstein				25a. DATE REC'D. BY REGISTRAR JUN 23 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

1880

20% COTTON LIBER

MADE IN U.S.A.

00-09798

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17632	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) WILLIAM T. CHANG										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6 15 1986	
3 SEX MALE 4 RACE ORIENTAL 5 DATE OF BIRTH MONTH DAY YEAR APRIL 25, 1963 6 AGE (IN YEARS) LAST BIRTHDAY 23 YRS. 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA 7b CITIZEN OF WHAT COUNTRY? UNITED STATES 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										2b DATE PRONOUNCED DEAD MONTH DAY YEAR 6 15 1986 2d HOUR 2:33 AM	
10 CITY OR TOWN OF DEATH Bethesda 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT 12b KIND OF BUSINESS OR INDUSTRY EDUCATION											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN ROCKVILLE 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS 14104 FLINT ROCK ROAD /20853											
14 FATHER'S NAME FIRST MIDDLE LAST KENNETH S. CHANG 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET LEE											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b SOCIAL SECURITY NO. 212-68-4255 17 INFORMANT KENNETH S. CHANG (FATHER) ADDRESS 14104 FLINT ROCK ROAD ROCKVILLE, MARYLAND 20853											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 2:10xx 6 15 1986 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Subject driver in auto-auto accident 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK street 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Old Georgetown & Beach Ave., Bethesda, Mont. 21f. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Mont. Maryland											
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita Korell M.D. Assistant MEDICAL EXAMINER DATE SIGNED 6/15/86											
EXAMINER'S NAME (TYPE OR PRINT) Margarita Korell, M.D. ADDRESS 111 Penn St., Baltimore, Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION 23b. DATE JUNE 17, 1986 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA											
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY ADDRESS FUNERAL HOMES PA 300 WEST MONTGOMERY AVENUE ROCKVILLE MARYLAND 25a. DATE REC'D. BY REGISTRAR JUN 18 1986 25b. REGISTRAR'S SIGNATURE J. Davidson											

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

00-2278-00



20% COTTON FIBER

Handwritten signature or mark.

00-11123

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 6 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Berrall Charest			2a. DATE OF DEATH MONTH DAY YEAR June 24, 1986			2b. HOUR 2:15 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4615 N. Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4615 N. Park Avenue/20815	
14. FATHER'S NAME FIRST MIDDLE LAST James --- Berrall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude --- Jenkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Miles Charest, Same address as #13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration + Hypovolemia Cerebrovascular Disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1</u> , 19 <u>86</u> , to <u>June 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June 21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <u>Clifton R. Gruver</u> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/24/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifton R. Gruver				22e. ADDRESS 1145 - 19th St., NW, Washington, D.C.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/26/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD				
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR JUL 1 - 1986						
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Henderson</u>										

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

BP

00-10630

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

17634

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helena Christmas		2a. DATE OF DEATH MONTH DAY YEAR 6-22-86		2b. HOUR 0940	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 5 34	
6. AGE (IN YEARS LAST BIRTHDAY) 51		7. IF UNDER 1 YEAR MONTHS DAYS 51 YRS.		8. IF UNDER 24 HRS. HOURS MIN. 0940	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nevis		9b. CITIZEN OF WHAT COUNTRY? United States		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper	
12b. KIND OF BUSINESS OR INDUSTRY Private Home		13a. STATE Virgin Islands		13b. CITY OR TOWN St. Croix	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Harbor View, Building 11, Apt. 140		14. FATHER'S NAME FIRST MIDDLE LAST Not Available	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Claxton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 580-10-3977	
17. INFORMANT Carmen Smith		ADDRESS 657 Houston Ave., Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Pseudomonas Skin Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION 4 Dec 85					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 22 Jan 86					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I, this hospital) attended the deceased from 4 Dec 85 to 22 Jan 86 , that (I/we) last saw the deceased alive on 22 Jan 86 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did not see the body after death.					
22a. SIGNATURE Thomas A. Bensinger MD					
DEGREE MD					
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. DATE SIGNED 6/23/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger					
22e. ADDRESS 7525 Greenway Cir Dr. Greenleaf MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/86		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.	
23d. LOCATION CITY OR TOWN Adelphi		COUNTY Prince Georges		STATE Md.	
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, 7400 Georgia Ave. N.W.					
ADDRESS Washington, DC					
25a. DATE REC'D. BY REGISTRAR JUN 26 1986					
25b. REGISTRAR'S SIGNATURE Walter R. Randle					

00-09071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, coroner or medical officer of health should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		86		17635		REG. NO.				
1. DECEASED NAME (PRINT) FIRST MIDDLE LAST Jeanette H. Cini					2a. DATE OF DEATH MONTH DAY YEAR June 6, 1986			2b. HOUR 4:10 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4-17-10		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MD.					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> XX	
14. FATHER'S NAME FIRST MIDDLE LAST Carl F. Heidt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Westphalen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 068-38-6768		17. INFORMANT Mr. John C. Cini, Son, 8234 Buckspark Lane West, Potomac, MD. 20854						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxemia and Hypercarbia DUE TO, OR AS A CONSEQUENCE OF (b) Advanced chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Atrial fibrillation; coronary artery disease; thyroid disorder										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-18-1986 to 6-6-1986, that (I) lost saw the deceased alive on 5-16-1986, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Joseph A. Romeo MD					DEGREE MD			22c. DATE SIGNED June 6, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo					22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 10 1986					

1760

James P. 1986 Galt of
Robert A. Thompson

0-09133

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17636

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Agnes Clarke			2a. DATE OF DEATH MONTH DAY YEAR 6-5-86 2b. HOUR 8:00A		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 11, 1889	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17305 Twin Ridge Court		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Duffy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Van Sant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-05-4135		17. INFORMANT Mary C. Clarke Daughter Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease and old age DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease and old age					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/28 19 86 to 6/5 19 86 , that (I) (we) lost 4/28 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.					
22b. SIGNATURE James Douglas Clarke M.D.				22c. DATE SIGNED 6/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES DOUGLAS CLARKE				22e. ADDRESS 5001 So. Hanover St., Balt., Md. 21230	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 7, 1986		23c. NAME OF CEMETERY OR CREMATORY George Washington	
23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. George's Md.		25a. DATE REC'D. BY REGISTRAR JUN 11 1986			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP. _____

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 4 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

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Washington - Alaska

Continental

U.S.A.

17502 West 10th Street

Montgomery

Van Sandt

Form 15

July 11, 1964

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June 7, 1964
Franklin J. Condit, Jr.
500 University Blvd., N.W.
Atlanta, Georgia 30303

00-11059

1 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 6 3 7

1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST EMMA M. COLLINS			2a. DATE OF DEATH MONTH DAY YEAR June 23, 1986		2b. HOUR 5:40A.M.		
1. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-14, 1906		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14925 Pennfield Circle		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. STREET ADDRESS / ZIP CODE 14925 Pennfield Circle 20906	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES RUMSEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FOREST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 578-44-3338		17. INFORMANT ADDRESS HUSBAND - JAMES M. COLLINS SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Cancer with metastasis DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Approximate interval between onset and death: 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9 19 83 , to 6 123 19 86 , that (I) (we) last saw the deceased alive on 2-7 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE [Signature]		DEGREE ATTENDING <input checked="" type="checkbox"/> PHYSICIAN MEDICAL <input type="checkbox"/> DIRECTOR STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (PRINT OR PRINT) A. ROTSTAMIN		22e. ADDRESS 3701 Rockmoor Blvd S. Spring Md 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MD.	
24. FUNERAL DIRECTOR (NAME) James [Signature]		24b. FUNERAL HOME DE VOL FUNERAL HOME WASHINGTON, D.C.		25a. DATE REC'D. BY REGISTRAR JUN 20 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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00-10323

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 3 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack L. Colvin			2a. DATE OF DEATH MONTH DAY YEAR 06 23 1986		2b. HOUR 12:20AM M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10 - 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (STATED FOR LAST 12 MONTHS OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Back Bay			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Howard Blacksville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 13967-Harrogate Pike Highland Md.					
14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Colvin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Martha H. Colvin				16. ADDRESS Hosbold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 579-50-6124		17. INFORMANT Noretha H. Colvin (13e)				17b. ADDRESS Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Bacterial pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Small cell carcinoma right lung										INTERVAL BETWEEN ONSET AND DEATH 3 d 1 wk 3 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Severe Disorder. Brain metastasis. Severe chronic obstructive pulmonary disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 19 82 to 6/23 19 86, that (I) (we) last saw the deceased alive on 6/22 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Donald E. Dillon MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 23 June 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon				22e. ADDRESS 2901 Olney Spring Road, Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE June 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Baltimore/Washington Crematory Laurel		23d. LOCATION CITY OR TOWN STATE P.D. MD					
24. FUNERAL DIRECTOR NAME Takoma Funeral Home-Washington, D. C.				25a. DATE RECEIVED BY REGISTRAR JUN 24 1986		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 3 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Mary Isabelle Cornwell			2a. DATE OF DEATH MONTH DAY YEAR 6 6 86		2b. HOUR 9P M
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 24 93	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 1a. STATE N/A 1b. COUNTY N/A	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6101 16th Street, N.W. 20011		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Sunderland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Wayson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 578-62-8145	17. INFORMANT Sister Apt. 10211 8811 Colesville Rd. Marie S. Vost Silver Spring, Md. 20910			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WKS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the decedent from 6/6/86 to 6/6/86, that (1) we last saw the decedent alive on 6/6/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.					
22b. SIGNATURE Barry N. Rosentau, M.D.		DEGREE M.D.		22c. DATE SIGNED 6/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENDAU		22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUN 11 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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00-09216

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

86 17640

1. DECEASED NAME (TYPE OR PRINT) Jean P. Crerar		2a. DATE KNOWN OF DEATH ESTIMATED June 19 86		2b. HOUR OF DEATH 4:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 24 91	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 24 91	7c. DATE PRONOUNCED DEAD June 19 86	7d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3404 Chiswick Ct. #18		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander McAllister		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Isabella Pratt		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
17. INFORMANT John D.M. Crerar		ADDRESS Silver Spring, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		DATE June 19 86	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Montg. Co., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION CITY OR TOWN Suitland, MD		23e. COUNTY Montgomery		23f. STATE MD	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016					
25a. DATE RECD. BY REGISTRAR JUN 24 1986					
25b. REGISTRAR'S SIGNATURE Julia Anderson					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-B4
25M

BP

DHMH - 17
(VR A15 ME (5))

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Silver Spring, Mont. Co., MD

John S. Rogers

6/2/86

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00-09279

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 1 7 6 4 1	
1. FOR STATE REGISTRAR		CHARLES B.		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CROOK		2a. DATE OF DEATH MONTH DAY YEAR 06 10 86 2b. HOUR 0945 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 18, 1915	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOIL SCIENTIST		12b. INDUSTRY OF AGRICULTURE U.S. GOV.			
13a. STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN ROCKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST ROY N. CROOK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORDELIA COOK		13d. STREET ADDRESS 1528 BAYLOR AVE. 20850	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 512-16-7206		17. INFORMANT ADDRESS MILDRED P. CROOK SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>ventricular arrhythmia</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe depression</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>gastitis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1980, 19, to 6/10, 1986, that (I) (we) last saw the deceased alive on 6/10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE John R. Melnich MD	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnich MD		22d. ADDRESS 16220 Frederick Road - Gaithersburg, Md. 20878		22e. DATE SIGNED 6/10/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 13, 1986		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT. MD.		24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR JUN 12 1986	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

00-00000

2028 COLLECTION
MEXICO



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00-10430

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 7 6 4 2 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OPAL MAE CULLUM				2a. DATE OF DEATH MONTH DAY YEAR JUNE 15 1986		2b. HOUR P M 9:45 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 27 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE WEST VIRGINIA		13b. COUNTY POTOMAC		13c. CITY OR TOWN HURRICANE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANKLIN THEODORE BENNETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA DELPHA ADKINS		13e. STREET ADDRESS / ZIP CODE BOX 55 25526			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 233-34-6625		17. INFORMANT ADDRESS ORLAND P. CULLUM, BOX 55, HURRICANE, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from JUNE 12, 1986 to JUNE 15, 1986 , that (I) (we) lost saw the deceased alive on JUNE 15, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE J. P. MEHEGAN				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 June 86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MEHEGAN, LT, MC, USN				22d. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-20-86		23c. NAME OF CEMETERY OR CREMATORY Adkins Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hinton, West Virginia	
24. FUNERAL DIRECTOR NAME Meadows Funeral Home Box 760, Hinton, WV 25951 ADDRESS				25a. DATE REC'D. BY REGISTRAR JUN 23 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 1B shows any injury or other traumatic event, the medical examiner must be notified of one.)

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 6 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MATTIE CURETON			2a. DATE OF DEATH MONTH DAY YEAR JUNE 28 1986			2b. HOUR 0118 M				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 7 25		6. AGE (IN YEARS LAST BIRTHDAY) 61 Y. 0. YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINK TOWN		12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE D.C. COUNTY N					13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4616 Kansas Avenue, N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Byrd					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Tynes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-30-6951		17. INFORMANT ADDRESS Mr. Oscar P. Cureton/husband/same as 13d					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Active hepatitis and cirrhosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 10 HOURS YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus, Renal insufficiency, Possible sepsis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 26 , 19 86 , to June 28 , 19 86 , that (I) (we) lost saw the deceased alive on June 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James Shaffer					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JUNE 28, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. SHAFFER					22e. ADDRESS 1011 N CAPITAL ST NE, DC 20002					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-2-86		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John T. Rhines Co., 3015 12th St. N.E., D.C. 20017					25a. DATE REC'D. BY REGISTRAR JUL 2 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

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00-08909

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17644

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Roy K. Davenport			2a. DATE OF DEATH MONTH DAY YEAR 6-2-86		2b. HOUR 5 A.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH November 24, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 77		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home	12a. USUAL OCCUPATION (STATE OR WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE District of Columbia	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 6351 Utah Avenue, N.W. 97999		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Davenport	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Preer	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 578-32-0026		17. INFORMANT ADDRESS Washington, DC Helen Bradby, daughter, 6351 Utah Avenue, NW			
18. CAUSE OF DEATH (Enter only one cause per part; (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Anthrax-like Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Intubation APPROXIMATE NOTION BETWEEN ONSET AND DEATH week year year					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Alzheimer's					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	21g. DATE OF OPERATION 5/22/86		
22a. I certify that (I) (this hospital) attended the deceased from above, (b) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE John G. Ward	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/2/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Ward		22e. ADDRESS 6116 Robbwood, Bethesda 20718			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 5, 1986	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home, 4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR JUN 9 1986	25b. REGISTRAR'S SIGNATURE John G. Ward		

MEDICAL CERTIFICATION

20900-0



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00-10097

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE A. DAWES			2a. DATE OF DEATH MONTH DAY YEAR JUNE 18, 1986		2b. HOUR 11:00 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Nov., 8, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator-Trash-Refuse		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Mont., Silver Spring	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7819 Piney Branch Road, 20910
14. FATHER'S NAME FIRST MIDDLE LAST Adolph M. Dawes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta F. Washington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-74-6703		17. INFORMANT ADDRESS Roland J. Dawes-Same as items #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) supraventricular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from June 6, 1986 to June 16, 1986 , that (I) (we) last saw the deceased alive on June 16, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Frederick B. Brennwald		DEGREE Attending Physician		22c. DATE SIGNED 6/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.W. BRENNWALD		22e. ADDRESS 831 University Blvd E, Silver Spring			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/21/86	23c. NAME OF CEMETERY OR CREMATORY Maryland National		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co., Md.
24. FUNERAL DIRECTOR Takoma Funeral Home-Washington, D. C.		25a. DATE REC'D. BY REGISTRAR JUN 20 1986		25b. REGISTRAR'S SIGNATURE Jane Dawson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

June 18, 1949

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 4 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		6/5/86		9 51 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
MALE		BLACK		November 16, 1905	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> YRS.	
JAMAICA		JAMAICA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		Holy Cross Hospital		Plumber	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		P.G. CO.		HYATTSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
SEYMOUR - DAVIS		ISADORA - (UNKNOWN)		NO NONE 579-04-0562	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
LUCILLE S. DAVIS (WIFE) SAME AS #13.		Depression		10 days	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF			
		DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
				86 6/5 86	
22a. I certify that (1) this hospital attended the deceased from above, (2) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M. L. LENKIN				6/6/86	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS		23c. DATE REC'D. BY REGISTRAR	
M. L. LENKIN		2309 SHOREFIELD RD WHEATON MD		JUN 12 1986	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY)		23e. DATE		23f. NAME OF CEMETERY OR CREMATORY	
CREMATION		JUNE 9, 1986		CHAMBERS CREMATORY	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
CHAMBERS FUNERAL HOME		SILVER SPRING, MD,		JUN 12 1986	
24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE	
Julia Davidson		Julia Davidson		Julia Davidson	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES U DEBEVOISE			2a. DATE OF DEATH MONTH DAY YEAR JUNE 28, 1986		2b. HOUR 5:20A M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 18, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Abraham - DeBevoise			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie - Covert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II	17. INFORMANT ADDRESS Ruth C. DeBevoise (Wife) Same as # 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 CHE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-27 , 19 86 , to 6-28 , 19 86 , that (I) (we) lost saw the deceased alive on 6-27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ROTSTEIN		22e. ADDRESS 3701 Rossman Blvd S. Spring Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 2 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

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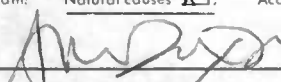
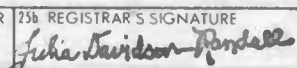
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 1 7 6 4 8

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NATALIE		FIRST S.		MIDDLE De		LAST JESUS		2b. DATE KNOWN OF DEATH MONTH DAY YEAR 6 6 1986		2c. HOUR 4:02	
3. SEX Female		4. RACE Spanish		5. DATE OF BIRTH MONTH DAY YEAR Mar. 1 1986		6. AGE (IN YEARS) MONTHS DAYS 3 5		7. IF UNDER 1 YR. HOURS MIN. 3 5		7b. IF UNDER 24 HRS.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		8b. CITIZEN OF WHAT COUNTRY? U. S. A.		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		11. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) None		12. KIND OF BUSINESS OR INDUSTRY	
13. CITY OR TOWN OF DEATH Takoma Park		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland. Prince George		16. CITY OR TOWN Hyattsville		17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		18. STREET ADDRESS 1414 University Blvd. East.	
19. FATHER'S NAME FIRST MIDDLE LAST Carmelo De Jesus		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esmerida Abreu		21. ADDRESS Bld. East. 1414 University		22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.		23. SOCIAL SECURITY NO. None		24. INFORMANT Carmelo De Jesus	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 6-7-86	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-9-86		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Riggs Rd. Hyattsville. Md					
24. DATE REC'D. BY REGISTRAR JUN 11 1986		25. REGISTRAR'S SIGNATURE 									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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Knoxville, Tennessee

Richard Wilson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 6 1 7 6 4 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Charles B Delph Sr.					2a. DATE OF DEATH MONTH DAY YEAR 06 23 1986			2b. HOUR 1:48 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
13a. STATE Md.					13b. COUNTY Howard		13c. CITY OR TOWN Dayton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elliott Delph					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO					16b. SOCIAL SECURITY NO. R25-32-2743		17. INFORMANT Charles Delph, JR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC ADENOCARCINOMA</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 12h MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>86</u> to <u>6/23</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>6/23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE K.F. Cheyney MD.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/23/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.F. CHEYNEY MD.					22e. ADDRESS MONTGOMERY GENERAL HOSPITAL ER. OLNEY MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-26-86		23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wheaton Montgomery Md.			
24. FUNERAL DIRECTOR NAME Slack Funeral Home					ADDRESS Box 268 Ellicott City, Md. 21043		25a. DATE REC'D. BY REGISTRAR JUN 26 1986		25b. REGISTRAR'S SIGNATURE	

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17650
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES W. DENNIS			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1986		2b. HOUR 2 A. M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-18-1892		6. AGE (IN YEARS LAST BIRTHDAY) 93 Years YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stinchcomb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-56-2762	
17. INFORMANT ADDRESS (Same as #13 above)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 3 weeks years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebral Vascular accident							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-2-86 to 6-29-86 , that (I) (we) last saw the deceased alive on 6-29-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tung-Pi Lee M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tung-Pi Lee M.D.		22e. ADDRESS 7411 Riggs Road Hyattsville MD 20783					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/1986		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md.	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home-Washington, D. C.		24b. ADDRESS 254 Carroll St., NW		25a. DATE REC'D. BY REGISTRAR JUL 1 - 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, notify injury, or other traumatic event, the medical examiner, and the medical examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1995, 2000, 2005, 2010, 2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, 2065, 2070, 2075, 2080, 2085, 2090, 2095, 2100, 2105, 2110, 2115, 2120, 2125, 2130, 2135, 2140, 2145, 2150, 2155, 2160, 2165, 2170, 2175, 2180, 2185, 2190, 2195, 2200, 2205, 2210, 2215, 2220, 2225, 2230, 2235, 2240, 2245, 2250, 2255, 2260, 2265, 2270, 2275, 2280, 2285, 2290, 2295, 2300, 2305, 2310, 2315, 2320, 2325, 2330, 2335, 2340, 2345, 2350, 2355, 2360, 2365, 2370, 2375, 2380, 2385, 2390, 2395, 2400, 2405, 2410, 2415, 2420, 2425, 2430, 2435, 2440, 2445, 2450, 2455, 2460, 2465, 2470, 2475, 2480, 2485, 2490, 2495, 2500, 2505, 2510, 2515, 2520, 2525, 2530, 2535, 2540, 2545, 2550, 2555, 2560, 2565, 2570, 2575, 2580, 2585, 2590, 2595, 2600, 2605, 2610, 2615, 2620, 2625, 2630, 2635, 2640, 2645, 2650, 2655, 2660, 2665, 2670, 2675, 2680, 2685, 2690, 2695, 2700, 2705, 2710, 2715, 2720, 2725, 2730, 2735, 2740, 2745, 2750, 2755, 2760, 2765, 2770, 2775, 2780, 2785, 2790, 2795, 2800, 2805, 2810, 2815, 2820, 2825, 2830, 2835, 2840, 2845, 2850, 2855, 2860, 2865, 2870, 2875, 2880, 2885, 2890, 2895, 2900, 2905, 2910, 2915, 2920, 2925, 2930, 2935, 2940, 2945, 2950, 2955, 2960, 2965, 2970, 2975, 2980, 2985, 2990, 2995, 3000, 3005, 3010, 3015, 3020, 3025, 3030, 3035, 3040, 3045, 3050, 3055, 3060, 3065, 3070, 3075, 3080, 3085, 3090, 3095, 3100, 3105, 3110, 3115, 3120, 3125, 3130, 3135, 3140, 3145, 3150, 3155, 3160, 3165, 3170, 3175, 3180, 3185, 3190, 3195, 3200, 3205, 3210, 3215, 3220, 3225, 3230, 3235, 3240, 3245, 3250, 3255, 3260, 3265, 3270, 3275, 3280, 3285, 3290, 3295, 3300, 3305, 3310, 3315, 3320, 3325, 3330, 3335, 3340, 3345, 3350, 3355, 3360, 3365, 3370, 3375, 3380, 3385, 3390, 3395, 3400, 3405, 3410, 3415, 3420, 3425, 3430, 3435, 3440, 3445, 3450, 3455, 3460, 3465, 3470, 3475, 3480, 3485, 3490, 3495, 3500, 3505, 3510, 3515, 3520, 3525, 3530, 3535, 3540, 3545, 3550, 3555, 3560, 3565, 3570, 3575, 3580, 3585, 3590, 3595, 3600, 3605, 3610, 3615, 3620, 3625, 3630, 3635, 3640, 3645, 3650, 3655, 3660, 3665, 3670, 3675, 3680, 3685, 3690, 3695, 3700, 3705, 3710, 3715, 3720, 3725, 3730, 3735, 3740, 3745, 3750, 3755, 3760, 3765, 3770, 3775, 3780, 3785, 3790, 3795, 3800, 3805, 3810, 3815, 3820, 3825, 3830, 3835, 3840, 3845, 3850, 3855, 3860, 3865, 3870, 3875, 3880, 3885, 3890, 3895, 3900, 3905, 3910, 3915, 3920, 3925, 3930, 3935, 3940, 3945, 3950, 3955, 3960, 3965, 3970, 3975, 3980, 3985, 3990, 3995, 4000, 4005, 4010, 4015, 4020, 4025, 4030, 4035, 4040, 4045, 4050, 4055, 4060, 4065, 4070, 4075, 4080, 4085, 4090, 4095, 4100, 4105, 4110, 4115, 4120, 4125, 4130, 4135, 4140, 4145, 4150, 4155, 4160, 4165, 4170, 4175, 4180, 4185, 4190, 4195, 4200, 4205, 4210, 4215, 4220, 4225, 4230, 4235, 4240, 4245, 4250, 4255, 4260, 4265, 4270, 4275, 4280, 4285, 4290, 4295, 4300, 4305, 4310, 4315, 4320, 4325, 4330, 4335, 4340, 4345, 4350, 4355, 4360, 4365, 4370, 4375, 4380, 4385, 4390, 4395, 4400, 4405, 4410, 4415, 4420, 4425, 4430, 4435, 4440, 4445, 4450, 4455, 4460, 4465, 4470, 4475, 4480, 4485, 4490, 4495, 4500, 4505, 4510, 4515, 4520, 4525, 4530, 4535, 4540, 4545, 4550, 4555, 4560, 4565, 4570, 4575, 4580, 4585, 4590, 4595, 4600, 4605, 4610, 4615, 4620, 4625, 4630, 4635, 4640, 4645, 4650, 4655, 4660, 4665, 4670, 4675, 4680, 4685, 4690, 4695, 4700, 4705, 4710, 4715, 4720, 4725, 4730, 4735, 4740, 4745, 4750, 4755, 4760, 4765, 4770, 4775, 4780, 4785, 4790, 4795, 4800, 4805, 4810, 4815, 4820, 4825, 4830, 4835, 4840, 4845, 4850, 4855, 4860, 4865, 4870, 4875, 4880, 4885, 4890, 4895, 4900, 4905, 4910, 4915, 4920, 4925, 4930, 4935, 4940, 4945, 4950, 4955, 4960, 4965, 4970, 4975, 4980, 4985, 4990, 4995, 5000, 5005, 5010, 5015, 5020, 5025, 5030, 5035, 5040, 5045, 5050, 5055, 5060, 5065, 5070, 5075, 5080, 5085, 5090, 5095, 5100, 5105, 5110, 5115, 5120, 5125, 5130, 5135, 5140, 5145, 5150, 5155, 5160, 5165, 5170, 5175, 5180, 5185, 5190, 5195, 5200, 5205, 5210, 5215, 5220, 5225, 5230, 5235, 5240, 5245, 5250, 5255, 5260, 5265, 5270, 5275, 5280, 5285, 5290, 5295, 5300, 5305, 5310, 5315, 5320, 5325, 5330, 5335, 5340, 5345, 5350, 5355, 5360, 5365, 5370, 5375, 5380, 5385, 5390, 5395, 5400, 54

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

00-08772

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17651

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | LAST | | 2a. DATE OF DEATH | | TH DAY YEAR | | 2b. HOUR | |
| JOSEPHINE | | de PERCIN | | JUNE 4, 1986 | | | | 10:50 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | APRIL 8, 1891 | | 95 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| NEW JERSEY | | U.S.A. | | | | Mont. Co. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | SCHOOL | |
| Bethesda | | Suburban Hospital | | TEACHER | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | | | |
| MARYLAND | | MONTGOMERY | | BETHESDA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 5721 GROSVENOR LANE 20814 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| CHARLES | | PAULUS | | LOUISE | | COLY | | ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 20816 | |
| NO | | NO | | NO | | NO | | FERNAND de PERCIN, 5328 WAPAKONETA RD., BETHESDA, MD. | |
| 18. CAUSE OF DEATH | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 912 | | | | DUE TO, OR AS A CONSEQUENCE OF | | Aspiration | | 1 week | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | 1 month | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| Generalized Arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | October 19 83 | | to June 4 19 86 | | that (I) (we) last saw the deceased alive on | | June 4 19 86 | |
| | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| John F. Gustafson | | M.D. | | June 4, 1986 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. SIGNATURE | | | | | |
| John F. Gustafson, MD | | 5480 Wisconsin Ave. Chevy Chase, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| CREMATION | | 6/5/86 | | METROPOLITAN CREMATORY | | ALEXANDRIA, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR | | NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| RICHARD RAPP, INC. | | 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | JUN 6 1986 | | John Davidson-Hopkins | | | |

17-00



STANDARD

00-12156

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in the funeral director's office. It should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8617652 | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1- FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Ellen | | MIDDLE
N. | | LAST
Depue | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR
10 ³⁰ AM | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
May 31, 1918 | | 6 AGE (IN YEARS LAST BIRTHDAY)
68 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Potomac | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8612 Bunnell Drive | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Retired Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8612 Bunnell Drive 20854 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
A. Gary Noyes | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minetta Douglas | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF KNOWN, WAS OR DATE)
WW II 142-26-9157 | | 17. INFORMANT ADDRESS
Robert H. Depue same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>End Stage Pulmonary Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Non-Small Cell Lung Cancer</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Non-Small Cell Lung Cancer</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 1</u> , 19 <u>86</u> , to <u>June 30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>June 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Mace Rothenberg, MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>7/1/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Mace Rothenberg, MD</u> | | | | 22e. ADDRESS
<u>Bethesda Naval Hospital</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
7/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veterans Cemetery | | 23d. LOCATION
Cheltenham, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>James Davidson</u> | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 6 1 7 6 5 3
REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Benjamin R. DITTO Jr | | | | | | | | 6 11 86 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | Caucasian | | 8 15 17 | | 68 YRS | | 230 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Kentucky | | U.S. | | | | Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF BUSINESS OR WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Kensington | | Kensington Gardens | | | | Broker | | Real Estate | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Montgomery | | Chevy Chase | | | | 4409 Ridge Street/20815 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Benjamin Russell Ditto, Sr. | | Mary Catherine Albany | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes WW II | | 578-01-2836 | | Diane E. Ditto, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alcohol</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>patient also had left heart lake pneumonia</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>5/21/86</i> to <i>6/1/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Thos G. WARD | | MD | | | | 6/1/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Thos G. WARD | | 6/16 Rockwood Bethesda 20817 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | June 3, 1986 | | Parklawn Mem. Park | | Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey | | Funeral Homes | | JUN 2 1986 | | | | | |
| 7557 Wisconsin Ave. | | Bethesda, MD 20814 | | | | | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 6 5 4

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN CLARA DOMBROWSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 30 86 | | | 2b. HOUR
800 M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 11 1910 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
8 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9308 OCALA STREET 20901 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9308 OCALA STREET 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PETER POMARZYSKI | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CLARA MAJCHRAK | | | 16. ADDRESS
Akron, Ohio 44321 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
105-07-2248 | | 17. INFORMANT
Son Charles H. Dombrowski | | 17b. ADDRESS
4224 Ridgewood Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASTROCYTOMA OF BRAIN
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 MOS. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION
11-8-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BRAIN TUMOR | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC. 19 79 to 6/30 19 86 , that (I) (we) lost
saw the deceased alive on 6/30 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James R. Coleman MD. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
7-1-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES R. COLEMAN | | | | 22e. ADDRESS
9241 COLUMBIA BLVD SILVER SPRING Md. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
July 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and keep both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 1B (showing injury, or other traumatic event, the medical examiner must be notified of once).

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617655

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
MARGARET T. DOUGHERTY | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 18 86 | | 2b. HOUR
12:43A | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
12-27-1893 | |
| 6. AGE (IN YEARS (LAST BIRTHDAY))
92 yrs. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adv. Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | 13a. STREET ADDRESS
Gaithersburg, Md
211 Russell Avenue 20877 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles H. Rowley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bernetta Marshall | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | |
| 16b. SOCIAL SECURITY NO.
216-10-1125A | | 17. INFORMANT
ADDRESS
Waynesboro, Va. 22980
Luther Trott Jr. 1318 Keesling Ave. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 days
10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (1) (this hospital) attended the deceased from Dec 10 19 85 , to June 18 19 86 , that (1) (we) lost
saw the deceased alive on June 17 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
James R. Moore Jr. | | DEGREE
MD | | 22c. DATE SIGNED
6-18-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS
207 Brookes Ave Gaithersburg | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
JUN 20 1986 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17656
REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) SOPHIA DRESNER | | | | 2a DATE OF DEATH
MONTH DAY YEAR
6/28/86 | | 2b HOUR
700 M | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
4/21/90 | | 6 AGE (IN YEARS LAST BIRTHDAY)
96 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b KIND OF BUSINESS OR INDUSTRY
Federal Govt. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
3a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6121 Montrose Rd. 20852 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Joseph Altschul | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie Rausch | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17 INFORMANT
ADDRESS
Gladys Scheckman 4 Monroe St. #402 Rockville, Md. 20850 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YEARS
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) HYPERTENSIVE CARDIOVASCULAR DISEASE 10 YEARS
DUE TO, OR AS A CONSEQUENCE OF: (c) ESSENTIAL HYPERTENSION 20 YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (this hospital) attended the deceased from 6/28/86 to 6/28/86 , that (we) last saw the deceased alive on 6/28/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | |
| 22b SIGNATURE
Steven Lipson | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6/29/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | | | 22e ADDRESS
6121 MONTROSE RD, ROCKVILLE | | | |
| 23a BURIAL, CREMATION, REMOVAL
Burial | | 23b DATE
June 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | 23d. LOCATION
CITY STATE
Adelphi, Maryland | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Haslam's FH. Falls Church, Va. | | | | 25a DATE REC'D. BY REGISTRAR
JUL 1 - 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Henderson | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00-10228

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 ! 7 6 5 1

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
VERNON E. DUVALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06 12 86 | | 2b. HOUR
3:00 PM |
| 3. SEX
MALE | 4. RACE
CAUCASION | 5. DATE OF BIRTH
MONTH DAY YEAR
11 18 96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 89 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARE BEL PRE HEALTH CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION |
| 13a. STATE
MD | | 13b. COUNTY
PRG | 13c. CITY OR TOWN
LAUREL | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM SPENCER DUVALL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH RICH | | 16. STREET ADDRESS / ZIP CODE
8501 MULBERRY ST. MD 20707 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NBS | | 16b. SOCIAL SECURITY NO.
111-10-4406 | | 17. INFORMANT
ELENE JOHNSON | |
| 18. ADDRESS
16712 OAK HILL RD 20824 | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c): Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (d) Coronary Artery Disease | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Disease | | | | | |
| 21a. DATE OF OPERATION
6/12/86 | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic Disease | | 21c. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6/12 1986 | | 21f. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 16b, PART 1 OR PART 2) | |
| 21g. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21h. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE
65 6/12 86 | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/12/86 to 6/12/86 that (1) (we) last saw the deceased alive on 6/12/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | 22c. DEGREE
MD | | 22d. DATE SIGNED
6/12/86 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
C. H. L. [Signature] | | 22f. ADDRESS
18111 Pr Philip Dr, Olney MD 20835 | | 22g. REGISTERAR'S SIGNATURE
[Signature] | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
6-14-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Burtonsville Maryland | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE
[Signature] | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Donaldson Funeral Home P.A. Laurel, Maryland | | | | | |



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00-10427

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 5 8
REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GERTRUDE EDWARDS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-17-86 | | 2b. HOUR
13:15 M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
1 1 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Connecticut | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Para-Legal | 12b. KIND OF BUSINESS OR INDUSTRY
Law | |
| 13a. STATE
New York | 13b. COUNTY
Unknown | 13c. CITY OR TOWN
New York | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
985 Lexington Avenue 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob Mendel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | 17. INFORMANT
ADDRESS
Takoma Park, Md.
Robin Smith, Dtr., 914 Larch Ave., 20912 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute Anterior Myocardial Infarction</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>10 DAYS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> , 19 <u>86</u> , to <u>June 16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June 16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Louis J. Larca</u> | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Louis J. Larca | | 22e. ADDRESS
7600 Carroll Ave, Takoma Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 21, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Mountain Grove Cemetery, Bridgeport, Fairfield Cty., | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bridgeport Conn. STATE | |
| 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS CO., 5801 Cleveland Ave., Riverdale, Md. | | 25. DATE REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE
JUN 23 1986 Julia Sanders-Randner | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-10236

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17659

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Margaret A Eggleston | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06/18/86 | | 2b. HOUR
5:55p | | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/22/07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Self-Employed | | 12b. KIND OF BUSINESS OR INDUSTRY
Seamstress | | |
| 13a. STATE
MD | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Silver Spr. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3340 Glen Egel Dr. 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Duffie | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Grace Ryan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
268-16-6560 | | 17. INFORMANT
ADDRESS
Clifford J. Eggleston Husband Same As 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) myocardial infarction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
10 days
2 weeks | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18 19 86 to 6/18 19 86 , that (I) (we) did saw the deceased alive on 6/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Marian Chung M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/18/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARIAN CHUNG, M.D. | | | 22e. ADDRESS
3701 Rossman Blvd. Silver Spring, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
June 20, 86 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Davidson | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY MED. EXAMINER

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|---|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JOHN R. FAIRFAX | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JUNE 28 1986 | | | | |
| 3. SEX MALE | | | | | 4. RACE BLACK | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR 6 18 03 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | | | | |
| 13a. STATE MD | | | | | 13b. COUNTY Montg. | | | | |
| 13c. CITY OR TOWN Gaithersburg | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS & ZIP CODE 368 N. Summit Ave | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert H. FAIRFAX | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH K. JOHNSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> | | | | | 16b. SOCIAL SECURITY NO. 216-22-0389 | | | | |
| 17. INFORMANT ADDRESS Robert Cotter Box 94 Dickerson, MD | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ISCHEMIC CARDIOMYOPATHY 20 YEARS | | | | | | | | | |
| (c) RENAL INSUFFICIENCY | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MULTIPLE, PRIOR MYOCARDIAL INFARCTIONS | | | | | | | | | |
| 19a. DATE OF OPERATION 6/21/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATECTOMY URINARY RETENTION | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NIA | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 86 , to 6/26 , 19 86 , that (I) (we) lost the deceased alive on 6/26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign this body after death. | | | | | | | | | |
| 22b. SIGNATURE Baron | | | | | DEGREE | | | 22c. DATE SIGNED 6/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY ARON | | | | | 22e. ADDRESS 50 W. EDMONSTON DR. ROCKVILLE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-2-86 | | 23c. NAME OF CEMETERY OR CREMATORY Warren Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg, Montg. MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 02 1986 | | 25b. REGISTRAR'S SIGNATURE Anita Benson-Rudner | | |



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 6 1
REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>MILDRED M FALLON</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>6-27-86</u> | | 2b. HOUR
<u>5:45pm</u> | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>8-06-02</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>83</u> YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington, D.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>MONTGOMERY</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>SILVER SPRING</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>HOLY CROSS HOSPITAL</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Clerk Typist</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>GPO</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u> | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>10210 Haywood Drive 20902</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Andrew J. Fallon</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Catherine A. Berry</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>213-48-6508</u> | |
| 17. INFORMANT
<u>Sister</u> | | 17. ADDRESS
<u>2419 Homestead Dr.</u> | | 17. NAME
<u>Margaret E. Collins Silver Spring, Md. 20902</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Asphyxia, Pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10/86</u> to <u>6/27/86</u> , that (I) (we) lost
saw the deceased alive on <u>6/27/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Tony P. Karmarkat</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Tony KARMARKAT</u> | | 22e. ADDRESS
<u>8201 16th ST SILVER SPRING MD-20910</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>July 1, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Francis J. Collins, Jr.</u>
<u>500 University Blvd., W. Silver Spring, Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>JUL 7 1986</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson Anderson</u> | | | | | | | |

MEDICAL CERTIFICATION

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1

DIVISION OF VITAL RECORDS, 201 W. PRATT ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that in death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1-11-51

Washington, D.C.
Dear Sirs:

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
Special Agent in Charge

7

Very truly yours,
Special Agent in Charge

00-10960

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17662
REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Irene ^{FIRST} FASIG ^{MIDDLE} C ^{LAST} | | 2a. DATE OF DEATH MONTH DAY YEAR
6-25-86 | | 2b. HOUR
11:20 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
06 03 1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | 13a. STREET ADDRESS / ZIP CODE
12922 Valley Wood Drive 20906 | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | |
| 14. FATHER'S NAME
Stephen ^{FIRST} Condors ^{MIDDLE} LAST | | 15. MOTHER'S MAIDEN NAME
Mary ^{FIRST} Bakos ^{MIDDLE} LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
184-12-2812 | | 17. INFORMANT
Marcelle C. Parialo | | ADDRESS
Sister Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 6/25/86 to 6/25/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE Dr. Tanke DEGREE MD | |
| 22c. DATE SIGNED 6/26/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Tanke | | 22e. ADDRESS
1030 Georgia Ave. N.W. Silver Spring Md 20906 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 28, 86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | 24. FUNERAL DIRECTOR NAME
Francis J. Collins, Jr. | | 25a. DATE REC'D. BY REGISTRAR | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | |

JUN 30 1986

STATE OF NEW YORK
COUNTY OF ...
IN SENATE
JANUARY 1, 1900

1883-84

| No. | | Name | | Age | | Sex | | Color | | Religion | | Profession | | Education | | Marital | | Status | | Remarks | |
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00-11040

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17663

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DORA | | | MIDDLE FELDMAN | | | LAST FELDMAN | | | 2a. DATE OF DEATH
MONTH 6 DAY 26 YEAR 86 | | | 2b. HOUR 9 MIN 30 | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH 3 DAY 31 YEAR 09 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse Administrator | | | 12b. KIND OF BUSINESS OR INDUSTRY
Clinic | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
6121 Montrose Road (20852) | | |
| 14. FATHER'S NAME
FIRST David MIDDLE Goldsmith LAST Goldsmith | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE (Unknown) LAST (Unknown) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----- | | | | | | | | |
| 16b. SOCIAL SECURITY NO.
130-28-9639 | | | 17. INFORMANT
ADDRESS Maryland 20815
Roger Feldman; Son; 18 Oxford Street; Chevy Chase, | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 DAYS | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) GANGRENE OF FEET | | | | | | | | | | | | 3 MONTHS | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) GENERALIZED ARTEROSCLEROSIS | | | | | | | | | | | | 5 YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA ALZHEIMER'S TYPE | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12/29 19 83 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET 12/29 19 83 to JUNE 26 19 86 | | | 21g. CITY OR TOWN PARAMUS COUNTY NEW JERSEY STATE NEW JERSEY | | | | | |
| 22a. I certify that (this hospital) attended the deceased from JUNE 26 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Steven Lipson | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
6/26/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | | 22e. ADDRESS
6121 MONTROSE RD, ROCKVILLE | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6/29/86 | | | 23c. NAME OF CEMETERY OR CREMATORY
Beth El Cemetery | | | 23d. LOCATION
CITY OR TOWN PARAMUS COUNTY NEW JERSEY STATE NEW JERSEY | | | | | |
| 24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS
NAME 1170 Rockville Pike; Rockville, Md. 20852 ADDRESS | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR JUN 30 1986 25b. REGISTRAR'S SIGNATURE Julia Sinden-Randner | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

birds

200

10/15

10/15

10/15

0-19269

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO.

17664

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CARM B FINK Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 28 86 | | | 2b. HOUR
7.06 AM | |
| 3. SEX
MALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 21 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
County | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assistant Treasurer | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Fink | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Beulah Holshauser | | 16. ADDRESS
9908 Holmhurst Road
Bethesda, Maryland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 453-14-9998 | | 17. INFORMANT (Wife)
Mary-Helen Fink | | 18. ADDRESS
9908 Holmhurst Road
Bethesda, Maryland | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CANCER of LUNG</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 YEARS |
|---|--|---|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>EMPHYSEMA, PULMONARY EMBOLI</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 27</u> , 19 <u>86</u> , to <u>JUNE 28</u> , 19 <u>86</u> , that (I) was lost saw the deceased alive on <u>JUNE 27</u> , 19 <u>86</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) would not (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Daniel Rosenblum</u> | | | | DEGREE
MD | | 22c. DATE SIGNED
6/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL ROSENBLUM | | | | 22e. ADDRESS
10400 CONVENT ST
KENSINGTON, MD 20895 | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
ADDRESS P.A. 7557 Wisconsin Avenue, Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson</u> | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 6 5
REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ERNST FLINK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 18 86 | | 2b. HOUR
11:35 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
MAR. 28, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ESTONIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GARDENER | 12b. KIND OF BUSINESS OR INDUSTRY
LANDSCAPING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
D.C. | 13b. COUNTY
WASHINGTON | 13c. CITY OR TOWN
WASHINGTON | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6200-OREGON AVE., NW | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CARL LUDWIG FLINK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALEXANDRIA VURMEISTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
482-36-4747 | | 17. INFORMANT
ADDRESS
REV. DR. REICHARD-NAT. LUTH. HOME, ROCKVILLE | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma,
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Primary Unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 26 , 19 83 , to June 18 , 19 86 , that (I) (we) last saw the deceased alive on June 13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Harold F. McCann | DEGREE
M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6-19-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | 22e. ADDRESS
4362-26th St. N. Arlington, Va. 22207 | |

| | | | |
|---|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
JUNE 23/86 | 23c. NAME OF CEMETERY OR CREMATORY
CONGRESSIONAL CEM | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON D.C. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HYSONG CO., INC-1300 N ST., NW WASH., DC | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JUN 30 1986 Julia Sander-Randall | |

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00-10533

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17066
REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | P M | |
| FIRST MIDDLE LAST | | 6 20 86 | | 11 P | |
| Joseph H FORER | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 75 YRS. | IF UNDER 24 HRS | |
| | | 8 11 10 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| NEW JERSEY | U.S.A. | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | Holy Cross | | Lawyer | | Law |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| MD | Montgomery | Sil. Sprg. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 711 Horton Dr. 20902 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | |
| Hymen Forer | | Pauline Klebansky | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-38-4490 | | Florence Forer Same as 13e | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CEREBRO VASCULAR | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF ACCIDENT (CVA) WITH | | | | | 7 Days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) CEREBRAL INFARCTION | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | |
| X | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | X | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6.14. 1986 to 6.20. 1986, that (I) (we) lost saw the deceased at 6.20. 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| ASIF S. QADRI | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 06-21-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| ASIF S. QADRI | | 4700 BERWYN HOUSE RD, COLLEGE PK | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Removal | | 6-21-86 | | Howard Univ. Med. Sch. | |
| 24. FUNERAL DIRECTOR NAME | | 23d. LOCATION CITY OR TOWN COUNTY | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| Thomas S. Ryan | | 712 Horton Drive Silver Spring MD. 20902 | | JUN 25 1986 | |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

0-16138

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00-09502

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 86 17667 | |
|---|--|--|--|---|--|---|--|--|------------------------------------|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERRIT DANGREMOND FREMOUW | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 12 1986 | | | 2b. HOUR
8:50 P | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 21 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED /COL. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.A.F. | | | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
ARLINGTON | | 13c. CITY OR TOWN
- | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3000 SPOUT RUN PKWY 99499 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN FREMOUW | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA CHRISTINE DANGREMOND | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1969 | | 16c. 127-05-0059 | | 17. INFORMANT ADDRESS
RUTH S. FREMOUW, 3000 SPOUT RUN PARKWAY, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 11 , 19 86 , to JUNE 12 , 19 86 that xx we last saw the deceased alive on JUNE 12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) | | | | | | | | | | | |
| 22b. SIGNATURE
<i>G.A. Calleja</i> | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
13 JUNE | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G.A. CALLEJA, LT, MC, USNR | | | | | 22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
June 18, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION
ARLINGTON, VIRGINIA STATE + | | | | | |
| 24. FUNERAL DIRECTOR NAME
IVES-PEARSON FUNERAL HOMES ARLINGTON, VA. 22201 | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Jane Vanden-Hendele</i> | | | | |

944999
DHMH - 16 60M 7/B4
(VRA 15, 4)

A

100%

20% cotton

MADE IN U.S.A.

0-09856

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17669
REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ISADORE ISIDORE | | 2a. DATE OF DEATH
MONTH DAY YEAR
06 15 86 | | 2b. HOUR
3:35 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC. 12, 1893 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HEBREW HOME OF GREATER WASH. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LAZER FREEDMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRAIDEL | | 12b. KIND OF BUSINESS OR INDUSTRY
TAILOR | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
212-30-7384A | | 17. INFORMANT
LEONARD FREEDMAN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS | | DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
OLD AGE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/15/86 to 6/15/86 , that (I) (we) last saw the deceased alive on 6/15/86 , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J.D. Patel | | DEGREE
M.D. | | 22c. DATE SIGNED
6/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.D. PATEL | | 22e. ADDRESS
6121 MONTROSE RD. ROCKVILLE MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JUNE 17, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
AGUDAS BNAI JACOB LODGE | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | 25a. DATE REC'D. BY REGISTRAR
JUN 19 1986 | |
| 25b. REGISTRAR'S SIGNATURE
J.D. Patel | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **17670**

**1. FOR
STATE
REGISTRAR**

| | | | | | |
|---|---------------------|--|--|---|--|
| 1. DECEASED NAME
FIRST ELSIE MIDDLE MARIE LAST FREE MAN | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 6 8 86 | | 2b. HOUR
12:00 PM |
| 3. SEX
F | 4. RACE
C | 5. DATE OF BIRTH
MONTH 5 DAY 13 YEAR 12 | 6. AGE (IN YEARS)
LAST BIRTHDAY 74 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 10. CITY OR TOWN OF DEATH
BETHESDA | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9710 PARKWOOD DR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE LAST Chesney | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
271-01-7233 | | 17. INFORMANT (Friend) ADDRESS
4501 Amherst La Crescence Kilcoyne Bethesda, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
- | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11 P.M. 6 8 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
FUND DROD IN BED | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
CITY OR TOWN BETHESDA COUNTY MD STATE MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Francis C Mayne | | TITLE (SPECIFY)
MD DEPT | | DATE SIGNED
6/9/86 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C Mayne | | ADDRESS
600 Wisconsin Ave Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 12, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | |
| 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Maryland | | 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey ADDRESS P.A. 7557 Wisconsin Avenue, Bethesda, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND TO THE FUNERAL DIRECTOR, PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 3, BETA, PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

A

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject. The next part of the report is a description of the methods used in the study. This is followed by a presentation of the results of the study. The final part of the report is a discussion of the results and their implications.

2. The second part of the report is a detailed description of the methods used in the study. This includes a description of the subjects, the materials, and the procedures. It also includes a description of the data collection and analysis methods. This part of the report is followed by a presentation of the results of the study. The final part of the report is a discussion of the results and their implications.

3. The third part of the report is a discussion of the results and their implications. It discusses the strengths and limitations of the study and suggests directions for future research. The final part of the report is a conclusion. This part of the report summarizes the findings of the study and their implications.

00-11029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed in the 72-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8 6 1 7 6 6 8 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Alice Diamond French | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
June 19 '86 | |
| 3. SEX
Female | | | | | | | | | | 7b. HOUR
M | |
| 4. RACE
White | | | | | | | | | | 5. DATE OF BIRTH MONTH DAY YEAR
March 12 1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
895 Quince Orchard Rd. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Md. | | | | | | | | | | 13b. COUNTY
Montgomery | |
| 13c. CITY OR TOWN
Gaithersburg | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
895 Quince Orchard Rd. #20878 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Bernard Diamond | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Laure Beauregard Diamond | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
220-46-2672 | |
| 17. INFORMANT ADDRESS
J. Laurence French, Jr. Gaithersburg, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Stomach 7 months
DUE TO, OR AS A CONSEQUENCE OF (b) Adenoc.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-8-86 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
As above - outlet obst. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-19-86 to 6-19-86 , that (I) last saw the deceased alive on 6-19-86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jack Schumacher M.D. | | | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6-19-86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Schumacher, M.D. | | | | | | | | 22e. ADDRESS
105 Russell Ave., Gaithersburg, Md. 20877 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation Burial | | | | 23b. DATE
6/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory St. Rose Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Gaithersburg, Montg. D.C. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Gartner Sandison F.H. 316 E. Diamond Ave. Gaithersburg, Md. 20877 | | | | | | | | | | | |
| DATE OF DEATH REGISTRAR'S SIGNATURE
Julia Sandison-Randall | | | | | | | | | | | |

CHIEFMAN

00-09516

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 176 71,
REG. NO.

| | | | | | | |
|--|---|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ELIthe Patrick FULLER | | | 2a. DATE OF DEATH MONTH DAY YEAR
6-15-86 | | 2b. HOUR
6:50 A.M. | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
11-01-97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co., MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stenotypist | | 12b. KIND OF BUSINESS OR INDUSTRY
Reporting Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Md. | | | 13c. CITY OR TOWN
Montg. Co. Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William E Uzzell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Cox | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | |
| 16b. SOCIAL SECURITY NO.
579-42-7014 | | 17. INFORMANT 2221 Colesville Road Silver Spring, Md. 20910
George B. Patrick Jr., M.D. | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CEREBROVASCULAR ACCIDENT**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
12 DAYSPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **DIABETES MELLITUS**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
6/14/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
6/15/86 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6/14/86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
6/15/86 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
6/15/86 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1106 Spring St. Silver Spring, MD. 20910 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/14/86 to 6/15/86 , that (I) (we) lost saw the deceased alive on 6/14/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Arnold G. Levy, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6/15/86 | |
| 22d. PHYSICIAN'S NAME (PRINT)
Arnold G. Levy, M.D. | | | | 22e. ADDRESS
1106 Spring St. Silver Spring, MD. 20910 | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 18, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |
| 7557 Wisconsin Ave. Bethesda, Maryland 20814 | | | | | | | |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

COLLIER

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the problem of the structure of the nucleus. It is shown that the structure of the nucleus is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

8
00-09640

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17672

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John Joseph Gaffney | | | 2a. DATE KNOWN
OF ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR June 11, 1986 | | | 2b. HOUR
DEATH MATED PM | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 13 1969 | 6. AGE (IN YEARS)
LAST BIRTHDAY 16 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE
PRONOUNCED
DEAD June 12 1986 | 7d. HOUR
440 P | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) CONNECTICUT | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
St. L. Spr | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1701 E.W. Highway Apt 102 | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS
OR INDUSTRY STEEL | | |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
St. L. Spr | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES - GAFFNEY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MOLLY - NEYLAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
047-05-3269 | | |
| 17. INFORMANT
MICHAEL J. GAFFNEY | | 18. ADDRESS
1843 MINTWOOD PL. NW
WASHINGTON, D.C. | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL
SIGNATURE John S. Rogers | | TITLE (SPECIFY)
MD | | MEDICAL EXAMINER | | DATE
June 11 1986 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) DR. JOHN S. ROGERS | | ADDRESS 1919 SEMINARY RD. SILVER SPRING, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
JUNE 16, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MICHAELS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
STRATFORD FAIRFIELD CO. CONNECTICUT | | |
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME | | ADDRESS
SILVER SPRING, MARYLAND | | 25a. DATE RECD. BY REGISTRAR
JUN 17 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (15))

00-10842

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|-------------------------------|
| 1. FOR STATE REGISTRAR | | 6 | | 17673 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | |
| Laurence | | Gaiser | | | |
| 2. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS)
LAST BIRTHDAY | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN |
| Male | White | July 13, 1948 | 37 YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED
WIDOWED | NEVER MARRIED
DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington, D.C. | USA | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | Rt. 29 near Crestwood Drive | Instrument Repairman | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS | |
| Maryland | Montgomery | Silver Spring | | 10609 Edgewood Avenue 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16. ADDRESS | |
| Joseph T. Gaiser | | Lorene | | Farmer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 213-54-5544 | | Mary I. Gaiser Wife Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
8160
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
2:15 P.M. 6-22 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto that ran into ditch | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
Rt. 29 near Crestwood Dr., Silver Spring, Montgomery Co., Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Dennis F. Smyth, M.D. | | Assistant | | 6-23-86 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St., Balto., Md. | | 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | June 25, 1986 | Glenwood Cemetery | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis J. Callins, Jr. | | JUN 30 1986 | | John Davidson | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | |

07/B4
25AA

BP

DHMH - 17
(VR A15 ME (5))

00-108-2

DATE: July 12, 1964

WASHINGTON, D.C. USA

The President Kennedy

1000 16th Street, N.W.

Room 5650

Washington, D.C.

20505

Dear Sir:

Enclosed

is

one

copy

of a letterhead memorandum dated July 12, 1964, from the



Very truly yours,

John F. Kennedy

President

John F. Kennedy Library, 200 N. St., Washington, D.C. 20540

00-09913

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17674
REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph F. Gantner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06-11-86 | | 2b. HOUR
7:30 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 24, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN INSANE ASYLUM, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(THREE WORK FOR ART OF WORKING LIFE)
Librarian | | 12b. KIND OF BUSINESS OR INDUSTRY
Libr. of Med. |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Chevy Chase | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Gantner | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabel Gravance | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
572-16-1037 | | 17. INFORMANT
ADDRESS
Dolores M. Gantner 4620 N. Park Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) atherosclerotic cardiovascular disease | | | | | INTERVAL BETWEEN ONSET AND DEATH
45 min.
48 hrs.
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/10 86 to 6/11 86 , that (I) (we) lost
saw the deceased alive on 6/10 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Samuel D. Goldberg MD | | DEGREE
MD | | 22c. DATE SIGNED
6/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel D. Goldberg MD | | 22e. ADDRESS
11125 Rockville Pike, Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
6/13/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc | | ADDRESS
5130 Wise Ave Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JUN 20 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Handwritten notes and stamps at the top of the page, including a date stamp "March 10, 1960" and a signature.

Handwritten notes and stamps in the middle section, including a date stamp "10-10-1960" and a signature.

Handwritten notes and stamps in the lower middle section, including a date stamp "10-10-1960" and a signature.

Handwritten notes and stamps at the bottom of the page, including a date stamp "10-10-1960" and a signature.

00-09280

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 7 5
REG. NO.

| | | | | | |
|--|------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN - GARKOSKY | | MONTH DAY YEAR
6 7 86 | | 11:15 AM | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
12 28 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SYLVAN MANOR HEALTH CARE CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEKEEPER | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STANLEY - GARKOSKY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY - UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
JULIE MERGEN | | 17. ADDRESS
1101 INWOOD AVE. SILVER SPRING MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial ischemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic heart disease</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19 1986, to 6-7 1986, that (I) (we) last saw the deceased alive on 6-6 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward Richards M.D. | | | | 22c. DATE SIGNED
6-7-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD RICHARDS M.D. | | | | 22e. ADDRESS
10301 GEORGIA AVE. SILVER SPRING, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
JUNE 8, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE PG. CO. MARYLAND | | 24. FUNERAL DIRECTOR
NAME ADDRESS
CHAMBERS FUNERAL HOME SILVER SPRING, MD. | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 12 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

73

1. The first part of the report is a general statement of the purpose of the study.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results of the study.

5. The fifth part of the report is a conclusion of the study.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

9. The ninth part of the report is a list of tables.

10. The tenth part of the report is a list of footnotes.

11. The eleventh part of the report is a list of acknowledgments.

12. The twelfth part of the report is a list of abbreviations.

13. The thirteenth part of the report is a list of symbols.

14. The fourteenth part of the report is a list of units.

15. The fifteenth part of the report is a list of other references.

7 6 7 6

DHMH - 17
(VR A15 ME (5))

00-09920

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17677

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lester H. Gilbert | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 12, 1986 | | 2b. HOUR
2:52 A.M. | |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 7, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Audio Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Voice of America |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5909 Namakagan Rd. 20816 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Allen Gilbert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amelia Kowalk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
107-09-6927 | | 17. INFORMANT
ADDRESS
Helen B. Gilbert Same As Item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia, Perforated gastric ulcer | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Respiratory Failure, Congestive Heart Failure, Diabetes | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-26-86 , 19 86 , to 6-12 , 19 86 , that (I) (we) lost
saw the deceased alive on 6-12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
James Brodsky | | DEGREE
MD | | 22c. DATE SIGNED
6-12-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James Brodsky, MD | | 22e. ADDRESS
4701 Willard Ave, Chevy Chase MD 20815 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/16/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Gate Of Heaven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | ADDRESS
5130 Wisc. Ave NW Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 7 8

REG. NO.

| | | | | | | | |
|--|--|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Franklin Upton GLADHILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 8, 1986 | | | 2b. HOUR
4:00 A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 7, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | |
| 10. CITY OR TOWN OF DEATH
Damascus | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11000 Bethesda Church Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dealer- Farm | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Implements | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
11000 Bethesda Church Rd. 20872 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Franklin Startzman Gladhill | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie Baker | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-32-1318 | | 17. INFORMANT
ADDRESS
Joyce Brown Gladhill, Item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 years
10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) was did not attend the deceased from 11/29 , 19 85 , to 6/8 , 19 86 , that (I) lost lost saw the deceased alive on 6/9/86 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above, (I) did not did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
James P. Kerr M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
June 9, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James P. Kerr, M.D. | | | | 22e. ADDRESS
26618 Ridge Rd., Damascus, Md. 20872 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 10, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus Meth. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Damascus, Montgomery, Md. | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, P.A., Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

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The Journal of Law, Economics, & Organization, V16 N1

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8617679 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) MARY GLICK | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 14 86 | |
| 3 SEX Female | | | | | | | | | | 2b. HOUR 9:30 AM | |
| 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH MONTH DAY YEAR 9 3 02 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | | | | | | | | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL ASSOC | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE Mass. | | | | | | | | | | 13b. COUNTY Suffolk | |
| 13c. CITY OR TOWN Chelsea | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David --- Segal | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dvora --- Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | | | | | | 16b. SOCIAL SECURITY NO. 018-36-3413 | |
| 17. INFORMANT Ryna Cohen | | | | | | | | | | 22 Farmington Ct., Chevy Chase, Md. 20815 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PULMONARY EMBOLI AND INFARCTION | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ----- | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOBIOGRAPHY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | 21e. PLACE OF INJURY | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 15, 1986 to JUNE 14, 1986 that (I) (we) last saw the deceased alive on JUNE 13, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Irwin Ardani DEGREE M.D. | | | | | | | | | | 22c. DATE SIGNED 6-15-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRWIN ARDANI, M.D. | | | | | | | | | | 22e. ADDRESS 5454 WISCONSIN AVE CHEVY CHASE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 6-16-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Intereth of Everett | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Everett Mass. | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chps | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 14 1986 | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file a certified autopsy.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

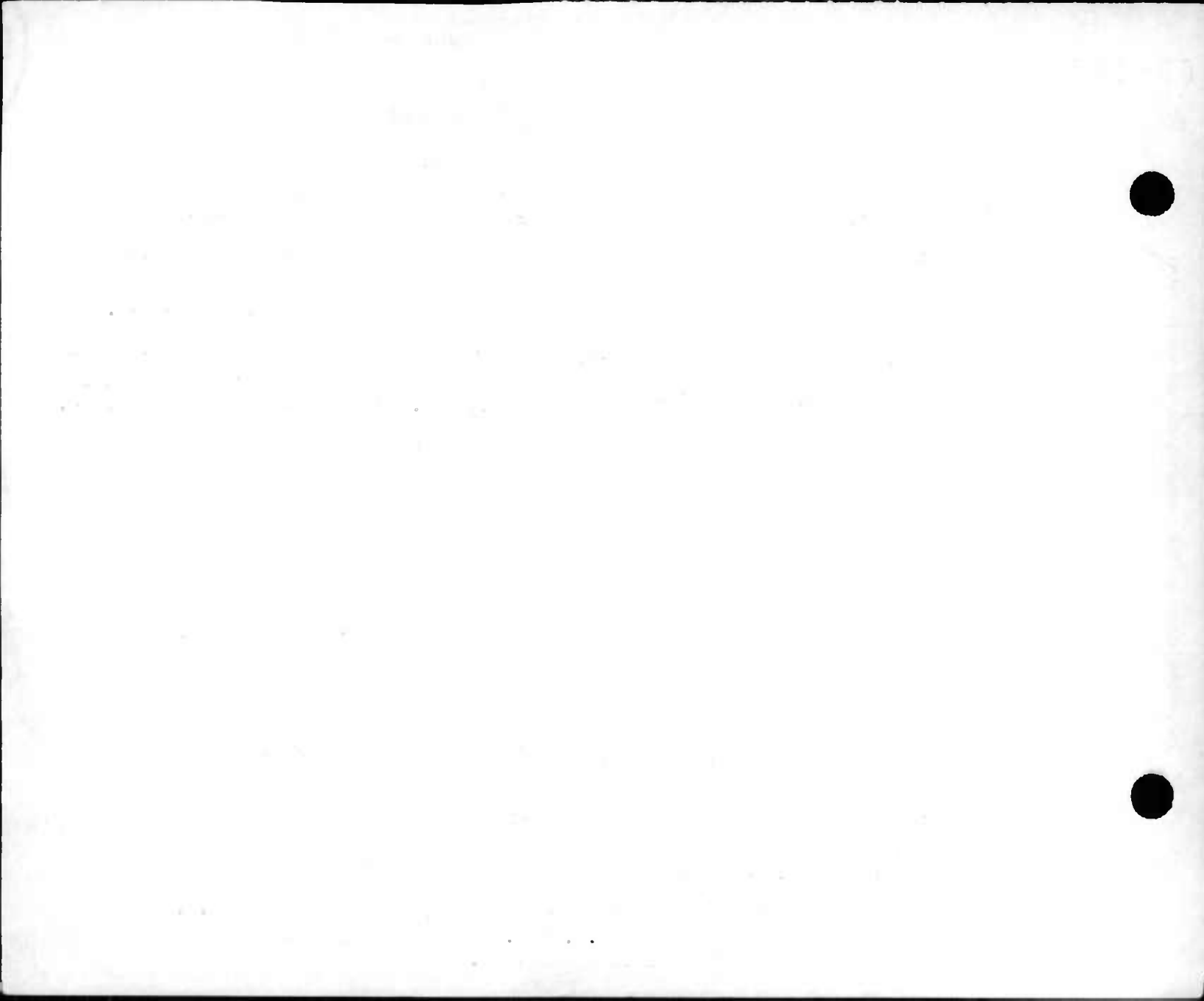
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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EMMA HELENE GOETTELMAHN | | | | 2a. DATE OF DEATH
MONTH 6 DAY 22 YEAR 86 | | 2b. HOUR
9:28 AM | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH June DAY 5 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
12000 Old Georgetown Rd. 20853 | | | | | | | |
| 14. FATHER'S NAME
FIRST William MIDDLE Schieder LAST Schieder | | | | 15. MOTHER'S MAIDEN NAME
FIRST Emma MIDDLE Schieder LAST Schieder | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
577-12-9324 | | 17. INFORMANT (daughter) Christine A. Goettelmann Gaithersburg, Md. 20879 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mass of right thalamus, with
DUE TO, OR AS A CONSEQUENCE OF
(b) Right medial herniation
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6, 1986 to June 22, 1986 , that (I) (we) last saw the deceased alive on June 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward A. Beeman | | | | DEGREE
M.D. | | 22c. DATE SIGNED
JUNE 22 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward A. Beeman, MD | | | | 22e. ADDRESS
8830 CAMERON ST.
SILVER SPRING MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
6-25-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Hines-Rinaldi Funeral Home | | | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE OF REGISTRATION
JUN 24 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

BP



00-11015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 8 1
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|-----------------------------------|----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH MONTH DAY YEAR | | 2c. HOUR | |
| REBECCA | | GOLDMAN | | June 21, 1986 | | 7:40 pm | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Female | White | MONTH DAY YEAR
Dec. 23, 1901 | | 84 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Israel | USA | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kensington | Circle Manor Nursing Home | | Housewife | | ----- | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | Montgomery | SilSpring | | 820 Hillsboro Drive 20902 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Israel Horowitz | | Hannah (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 153-03-7950D | | Ann Zirkind; 820 Hillsboro Dr., Sil. Spg, Md. 20902 | | | |

| | | | |
|--|--|--|-------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | ----- | |
| IMMEDIATE CAUSE (a) Cardio Respiratory Arrest | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF | | years |
| | (b) Arteriosclerotic Cardiovascular Dis. | | |
| | DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 1984, to June 21, 1986, that (I) xx lost saw the deceased alive on June 16, 1986, and that in (my) (x) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| BENJAMIN AVRUNIN, M.D. | | | | | | 6-21-1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| BENJAMIN AVRUNIN, M.D. | | 3720 Farragut Ave., Kensington, Md. | | | | | |

| | | | | | | | |
|---|--|-------------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 6-23-1986 | | Riverside Cem. | | Rochelle Park, N.J. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike | | JUN 25 1986 | | Julia Danden-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

00-09912

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 8 2
REG. NO.

| | | | | | | | |
|---|--|--|---|---|-------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HILDA THELMA GOLDSTEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 10 86 | | 2b. HOUR
200p^M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 22, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Potomac | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11316 Woodington Terrace | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
D.C. | | | | 13b. CITY OR TOWN
Wash., D.C. | | 13c. STREET ADDRESS / ZIP CODE
3001 Veazy Terrace, N.W., #1411 (20008) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Heller | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Lefsky | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
208-24-2264 | | 17. INFORMANT
Potomac, Maryland 20854
Ira Apatoff; Son-in-Law; 11316 Woodington Terr. | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Carcinoma of the Vagina (5-85)**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**6-86**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 22, 19 86 to June 10, 19 86 , that (I) (we) last
saw the deceased alive on June 9, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (will not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Richard W. Holt, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6-10-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard W. Holt, M.D. | | | | 22e. ADDRESS
3800 Reservoir Rd., N.W.D.C. 20007 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Fairfax; Va. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DANZANSKY-GOLDBERG MEMORIAL CHAPELS,
1170 Rockville Pike; Rockville, Md. 20852 | | | | 25. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
 signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31220-00

DDMM

IBLS

[Faint, illegible text and markings covering the page]

00-509724

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17683

1- STATE REGISTRAR

2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Margory Jane Golov

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 8 13 42 6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. 9. DATE OF DEATH MONTH DAY YEAR 6 6 86 10. DATE OF DEATH MONTH DAY YEAR 6 6 86 11. DATE OF DEATH MONTH DAY YEAR 6 6 86 12. DATE OF DEATH MONTH DAY YEAR 6 6 86 13. DATE OF DEATH MONTH DAY YEAR 6 6 86 14. DATE OF DEATH MONTH DAY YEAR 6 6 86 15. DATE OF DEATH MONTH DAY YEAR 6 6 86 16. DATE OF DEATH MONTH DAY YEAR 6 6 86 17. DATE OF DEATH MONTH DAY YEAR 6 6 86 18. DATE OF DEATH MONTH DAY YEAR 6 6 86 19. DATE OF DEATH MONTH DAY YEAR 6 6 86 20. DATE OF DEATH MONTH DAY YEAR 6 6 86 21. DATE OF DEATH MONTH DAY YEAR 6 6 86 22. DATE OF DEATH MONTH DAY YEAR 6 6 86 23. DATE OF DEATH MONTH DAY YEAR 6 6 86 24. DATE OF DEATH MONTH DAY YEAR 6 6 86 25. DATE OF DEATH MONTH DAY YEAR 6 6 86 26. DATE OF DEATH MONTH DAY YEAR 6 6 86 27. DATE OF DEATH MONTH DAY YEAR 6 6 86 28. DATE OF DEATH MONTH DAY YEAR 6 6 86 29. DATE OF DEATH MONTH DAY YEAR 6 6 86 30. DATE OF DEATH MONTH DAY YEAR 6 6 86

11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CAMBRIDGE MASS 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 14. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD

15. CITY OR TOWN OF DEATH BETHESDA 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 5225 POOKS HILL RD. 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER 18. KIND OF BUSINESS OR INDUSTRY HOME

19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20. STATE MD. 21. COUNTY MONTGOMERY 22. CITY OR TOWN BETHESDA 23. INSIDE CITY LIMITS? YES ☒ NO ☐ 24. STREET ADDRESS 5225 POOKS HILL RD. 25. FATHER'S NAME FIRST MIDDLE LAST ARNOLD GOLOV 26. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA STANETSKY

27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 28. SOCIAL SECURITY NO. 022-32-3777 29. INFORMANT ADDRESS 220 COUNTRY DR. WESTON MASS.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drug over Dose
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c)
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion
ACTUAL SIGNATURE John Tauber TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 6-7-86 BETHESDA MD.
EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 WISCONSIN AVE

23a. BURIAL, CREMATION, REMOVAL (15) BURIAL 23b. DATE JUNE 10-86 23c. NAME OF CEMETERY OR CREMATORY SHARON MEM PK. 23d. LOCATION CITY OR TOWN COUNTY STATE NORFOLK CO. MASS.
24. FUNERAL HOME DANZANSKY-GOLDBERG MEM CHP INC. 1170 ROCKVILLE PK. ROCKVILLE MD. 25. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 19. RETAIN PAGE 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

REC'D COLLECTIONS

1/11/1968



1/11/1968

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as having occurred, the medical examiner must be notified at once.

Dr. Tamberlin, Medical Examiner, approved.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 6 1 7 6 8 4
REG. NO. | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Bertha Oshei Gordon | | | | June 12, 1986 | | | | 7:20 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 29, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6001 Gloster Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6001 Gloster Rd. 20816 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Oishel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Julia Roffo | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
579-60-4065 | | 17. INFORMANT
Laura G. Worth | | ADDRESS
Same As Item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>instantaneous</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic heart disease with coronary insufficiency</u> | | | | | | | | 220445
2 1/2 years | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 28</u> , 19 <u>66</u> , to <u>June 12</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 12</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William O. Bailey, Jr. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7b. DATE SIGNED
6/12/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William O. Bailey, Jr. | | | | 22e. ADDRESS
2737 Devonshire Place N.W.
Washington, D.C. 20008 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/16/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons, Inc. | | | | 5130 Wisc. Ave NW
Washington, D.C. | | 25a. DATE REC'D BY REGISTRAR
JUN 10 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | | | |

NOTICE NO. 203

June 1, 1962

London

Paris

Brussels

London

Paris

June 1, 1962

90

London

New York

London

New York

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London

New York

London, June 1, 1962

London, June 1, 1962

London

London

London

London

London, June 1, 1962

London, June 1, 1962

00-09587

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 6 1 7 6 8 5 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
SUSAN CAROL GRANGER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JUNE 13, 1986 | | | |
| 3. SEX
FEMALE | | | | 2b. HOUR
1:40P M | | | |
| 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 17, 1953 | | 6. AGE (IN YEARS LAST BIRTHDAY)
32
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing Student | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT J. MILLER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WILMA A. SLONAKER | | 13e. STREET ADDRESS / ZIP CODE
3715 CARRISSA LANE 20832 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
216-64-3895 | | 17. INFORMANT
ADDRESS
MR. STEDE W. GRANGER (HUSBAND) SAME#13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>12 Days</u>
<u>2 Years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 13,</u> 19 <u>78</u> to <u>JUNE 13,</u> 19 <u>86</u> that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>JUNE 13,</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>J. Greenberg</u> | | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH, 9000
ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JUNE 17, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
LAYTONSVILLE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAYTONSVILLE MONT. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 17 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

BP

100-000000

7



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 8 6

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Helen Greenfield | | 2a. DATE OF DEATH MONTH DAY YEAR
6 11 86 | | 2b. HOUR
2⁴⁵ M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
5 9 1996 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 13a. STATE
md | | 13b. COUNTY
montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Herman Blum | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rose (Unknown) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
130-26-4793 | |
| 17. INFORMANT ADDRESS
Bowie, Md. 20715 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 d
1 d | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
UTI | | | | | | | |
| 19a. DATE OF OPERATION
8/12 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
UTI | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/12 , 19 81 , to 6/11 , 19 86 , that (I) (we) last saw the deceased alive on 6/11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
PETER B. SHERER MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER B. SHERER MD | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Moses Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Farmingdale, New York | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEMORIAL CHAPELS
NAME ADDRESS
1170 Rockville Pike; Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03421

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Hole", "W.H.", and "N.Y." are partially visible.]

00-09663

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified immediately.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17681

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RUTH GREIGY | | 2a. DATE OF DEATH MONTH DAY YEAR
6 8 86 | | 2b. HOUR
9:17 M | |
| 3. SEX
F | | 4. RACE
C 1 | | 5. DATE OF BIRTH MONTH DAY YEAR
6 22 22 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Capsco, Inc. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 13a. STREET ADDRESS / ZIP CODE
2801 New Mexico Ave., NW, #1216 | |
| 13a. STATE
D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN
Washington | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Morris Solomon | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Fannie Martin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
143-18-1078 | | 17. INFORMANT
Charles Sherman | | 17. ADDRESS
2801 New Mexico Ave., #1216 Washington, D.C. 20007 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
None |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. certify that (I) (this hospital) attended the deceased from 1/8 1986 to 6/8 1986 , that (I) (we) lost saw the deceased alive on 1/8 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Joel Scherman | | DEGREE Consultant
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joel Scherman | | 22e. ADDRESS
9410 old Georgetown Rd Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Adelphi Maryland | | 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Mem. Chps. Rockville, Md 20852 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 22 1986 | | 25b. REGISTRAR'S SIGNATURE
Gilia Davidson-Randall | | | |

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DHMH 16-00M 7/84
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 6 8 8
REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | Charles Gibson Grey | | June 18, 1986 | | 12:25P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | 5 20 08 | | 78 YRS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington, DC | | U.S. | | | | Montgomery MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Olney | | Montgomery General Hospital | | Veterinarian | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Howard | | Woodbine | | 2435 Duvall Rd. 21797 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 17. SOCIAL SECURITY NO. | |
| Charles C. Grey | | Elizabeth E. Catteron | | No | | 216-44-9683 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | 19. RESPIRATORY CIRCULATORY | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 15 min | |
| 21. DUE TO, OR AS A CONSEQUENCE OF | | 22. BRAIN STROKE CVA | | 23. 5 days | | | |
| 24. DUE TO, OR AS A CONSEQUENCE OF | | 25. ARTERIO SCLEROTIC DISEASE (H.D.) | | 26. years | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 21g. I certify that (1) this hospital attended the deceased from saw the deceased alive or above; (2) I (did not) view the body after death. | | 21h. SIGNATURE | | 21i. DEGREE | | 21j. DATE SIGNED | |
| 21k. PHYSICIAN'S NAME (TYPE OR PRINT) | | 21l. ADDRESS | | 21m. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 21n. DATE SIGNED | |
| Charles Ligon, M.D. | | 18117 Ft. Philip Dr. Olney Md 20831 | | | | 6/19/86 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Removal | | 6-18-86 | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Anatomy Board | | Balto., Md. | | JUN 20 1986 | | Julia Davidson-Pandora | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (b) (1), shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 86 17689 | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARION P. GRIFFIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 7 86 | | | 2b. HOUR
0120 M | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
3 18 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
78 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
md | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
40 Russell Ave Apt 308 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
LeRoy D. Peavey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances Nottage | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
023-01-7655 | | 17. INFORMANT ADDRESS
Rev. J. Melvin Griffin Gaithersburg, Md. 20877 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA - CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION - CHRONIC DISEASE - PHARYNGEAL
DUE TO, OR AS A CONSEQUENCE OF (c) PHARYNGEAL DYSPLASIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
10 DAYS
20 YEARS
28 YEARS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
VENTRICULAR ECTOPY DIABETES | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1/86 to 6/7/86 , that (I) (we) last saw the deceased alive on 6/7/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
MD | | | | 22c. DATE SIGNED
6/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR GREGORY L. BELL MD | | | | 22e. ADDRESS
13 E. PEARL PARK DR. GAITHERSBURG MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Emory Church Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Street Hartford Md. | | | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | | | 25a. DATE REC'D BY REGISTRAR
6/12/86 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

BP

[illegible]

00-09254

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 show the injury, or other traumatic event, the medical examiner should be notified on page 4.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17690
REG. NO.

| | | | | | |
|--|-------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RUTH D. GRIMES | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-6-86 | | 2b. HOUR
4-34P M | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
9 2 38 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | | 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RESTAURANT MANAGER RESTAURANT | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
7733 RIVERDALE RD. # 204 | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
NEW CARROLTON | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RAYMOND JONES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WILLIE RUTH SHAW | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
241-58-5965 | | 17. INFORMANT
JAMES L. GRIMES, NEW CARROLTON, MARYLAND | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) RUPTURED ANEURYSM
DUE TO, OR AS A CONSEQUENCE OF
(c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
① HYPERTENSION. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 5, 1986 , to JUNE 6, 1986 , that (I) (we) lost
saw the deceased alive on JUNE 6, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mohammed A. Mannan M.D. | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MOHAMMED A. MANNAN | | | | 22e. ADDRESS
3715 RHODE ISLAND AVE
MOUNT RAINIER, MD. 20712 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
6/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND P.G. MARYLAND | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JUN 12 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
J.B. JENKINS FUNERAL HOME, LANDOVER, MARYLAND | | | | | |

BP

0-09363

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

6

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7

6

9

1

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES ALBERT GROWER | | | 2a. DATE OF DEATH
MONTH 6 DAY 7 YEAR 86 | | | 2b. HOUR 10:30 AM | | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH 7 DAY 10 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oil City Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5204 Russett Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MARKETING SPECIALIST | | | 12b. KIND OF BUSINESS OR INDUSTRY
GRAPHICS | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN Rockville | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
5204 Russett Road 20853 | | |
| 14. FATHER'S NAME
FIRST JOSEPH MIDDLE FRANCIS LAST GROWER | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST GENEVIEVE MIDDLE HELEN LAST MCDONNELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
176-12-2712 | | 17. INFORMANT
PATRICIA G. SCHAFER | | | | ADDRESS
9 VALLEY ROAD DANBURY, CT 06811 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LIVER
DUE TO, OR AS A CONSEQUENCE OF
(b) ADENOCARCINOMA SITE UNSPECIFIED
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1986</u> to <u>June 7, 1986</u> , that (I) (we) lost <u>the deceased alive on June 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE
Bernard A. Fitzgerald M.D. | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-7-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD A. FITZGERALD | | | | | | 22e. ADDRESS
217 UNIVERSITY BLVD E, Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | | 23d. LOCATION
(CITY OR TOWN)
Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc.
ADDRESS 1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

100-620-

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00-10832

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 6 9 2
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JANET Marie GUE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-25-86 | | | 2b. HOUR
1615 M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 21, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
66 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
Fayette | | 13c. CITY OR TOWN
Brownsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
919 York Street. 15417 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Dudek | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophie Not Available | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
197-30-5647 | | 17. INFORMANT
ADDRESS
Donald W. Gue Same as # 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) WIDESPREAD METASTATIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF COLON (POST OPERATIVE)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
6 MONTHS
12 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION
6/18/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
OBSTRUCTING CARCINOMA OF SIGMOID | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6/14/86 19 to 6/25 19 86 | | 22a. I certify that: (1) (this hospital) attended the deceased from 6/25 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | |
| 22b. SIGNATURE
William H. Jackson | | 22c. ADDRESS
1125 Rockville Pike | | 22d. DATE SIGNED
6/26/86 | | 22e. REGISTERAR'S NAME (TYPE OR PRINT)
Wm H Jackson | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 28, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
LaFayette Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brier Hill Fayette Penna. | | | |
| 24. FUNERAL DIRECTOR Robert A Pumphrey | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Galia Davidson | | | |
| 25c. ADDRESS
7557 Wisconsin Avenue. Bethesda, Maryland | | | | | | | | | |

MEDICAL CERTIFICATION

A

3-1-1952

Mr. J. Edgar Hoover
U. S. Department of Justice
Washington, D. C.

Dear Sir:
I am writing to you regarding
the matter of the
White House telephone
taps.

On 1-1-52, I received
a letter from you dated
12-1-51.

I am sorry that I
have not been able to
reply to you earlier.
I am sure that you
will understand my
position.

00-10839

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17693 | |
|--|--|-----------|--|------------------|------------------------------------|--|---|--|---|--|-----------------------------------|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Lucy | | | Cuterman | | | June 18, 1988 | | | 8:30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | |
| Female | | Caucasian | | 11 28-26 89 YRS. | | MONTHS DAYS HOURS MIN. | | June 19, 1988 | | 8:30 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Connecticut | | | USA | | | | | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | | | Holy Cross Hosp | | | | | | Secretary | | Revere Corp. |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 20901 |
| Maryland | | | Montgomery | | Silver Spring | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4 Oldham Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Edward August Guterman | | | Emma Augustin | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 042-05-7328 | | | Lauren E. Seifert Nephew Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>Hypertension and Anemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| None | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | MEDICAL EXAMINER | | | DATE SIGNED | | |
| John S. Rogers | | | M.D. 12 yr | | | | | | June 19, 1988 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| John S. Rogers, M.D. | | | 1919 Seminary Road Silver Spring, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | June 24, 1988 | | Walnut Grove Cemetery | | | Meriden New Haven Connecticut | | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Francis J. Collins, Jr. | | | JUN 30 1988 | | | Julia Burden | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |

07-B4
25M

BP
DHMH - 17
(VR A15 ME (5))

PAID 100% 100%

WINTER



00-10003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617694
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SAMUEL ALEXANDER GUTTENTAG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 16, 1986 | | | 2b. HOUR
1:35a. M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 26, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Boston, Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement & Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
I.R.S. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3901 Harrison Street, N.W. (20015) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Guttentag | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Cohen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWI | | | 16b. SOCIAL SECURITY NO.
364-46-0112 | | 17. INFORMANT
ADDRESS Wash., D.C. 20015
Joseph Guttentag; Son; 3901 Harrison St., N.W.; | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>CORONARY ARTERY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>IMMED</u>
<u>2 YEARS</u> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT</u> , 19 <u>85</u> , to <u>JUNE</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Jon M. Wiseman</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
June 16, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JON M. WISEMAN, M.D. | | | | 22e. ADDRESS
5410 Conn. Avenue, N.W., Suite 102; Wash., D.C. 20015 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Chevra Kadusha Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woburn, Massachusetts | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS 1170 Rockville Pike; Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 19 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Tindon-Randall</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-11003



20000
20000

20000 20000

20000 20000

0-11127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 86 17695 | |
|--|-------------------------|--|--|---|-------------------------------|---|--|--|--|---|--|
| FOR STATE REGISTRAR | | | | | | | | | | REC'D. 1986 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Richard L. Gurican</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
<i>June 29 1986</i> | |
| 3. SEX
<i>M</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Oct 4 37</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>48 YRS.</i> | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
<i>June 29 1986</i> | | 2b. HOUR
<i>1:30 PM</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>IOWA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Sil. Spg</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>PAINTER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>Montg</i> | | 13c. CITY OR TOWN
<i>Sil. Spg</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>ANDREW JOHN GURICAN</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ALTA LANE</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>YES</i> | | 16b. SOCIAL SECURITY NO.
<i>579-52-1193</i> | | 17. INFORMANT
<i>MRS ALTA L. MCCARTHY</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Over dose</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Heart Medication</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>None</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>9:42 PM 1986</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<i>Overdose Medication</i> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<i>Home</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Black Rd Sil. Spg Montg. MD</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John D. Rogers</i> | | TITLE (SPECIFY)
<i>Days</i> | | MEDICAL EXAMINER | | DATE SIGNED
<i>June 29 1986</i> | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| 23a. DATE OF BURIAL, CREMATION, REMOVAL
<i>7/2/1986</i> | | 23b. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek</i> | | 23c. LOCATION
CITY OR TOWN COUNTY STATE
<i>WASHINGTON, D.C.</i> | | 23d. DATE REC'D. BY REGISTRAR
<i>JUL 1 - 1986</i> | | | | | |
| 23e. REGISTRAR'S SIGNATURE
<i>John D. Rogers</i> | | 23f. REGISTRAR'S SIGNATURE | | 23g. REGISTRAR'S SIGNATURE
<i>John D. Rogers</i> | | | | | | | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

WASHINGTON, D.C.

PAINTER

USA

John

ANDREW JOHN GURIAN ALTA

VIETNAM 21-23 APR 1975

YES

WASHINGTON, D.C.

THOMAS ROSE (REX)

254 CARROLL ST. N. W. D. C. 1

00-11124

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 86 | 17696 | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|-------|--|--|----------------------|--|----------|--|
| 1- STATE REGISTRAR | | | | | | | | | | VERA | | D. Haggerty | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Vera D. Haggerty | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-25-86 | | 2b. HOUR
8:45 AM | | | | | |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 15, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | IF UNDER 24 HRS.
HOURS MIN.
YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mississippi | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. COUNTY
Montgomery | | 13d. CITY OR TOWN
Chevy Chase | | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John A. McNeil | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
A. Lonie Howell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-54-8842 | | 17. INFORMANT
ADDRESS
Robert J. Haggerty 5344 Broad Branch Rd. NW | | 17b. ADDRESS
Wash., DC 20015 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Stroke (Massive cerebral infarction)
DUE TO, OR AS A CONSEQUENCE OF
(c) Infarction | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Congestive Heart Failure | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15, 1986 to June 25, 1986 , that (I) (we) last saw the deceased alive on June 25, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | | | | | 22c. DATE SIGNED
6/25/86 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Boo K. Kim | | | | | | | | | | 22e. ADDRESS
8921 Shady Grove St | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/28/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 WI Ave. NW Wash., DC 20016 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 1 - 1986 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Henderson | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

00-1115
Vene D. Agency

Female White Nov. 12, 1907

Mississippi U.S.A. x

Home Tennessee

Montgomery Chevy Chase x 4014 Oliver St.

John A. Nov. 12, 1907 Louisiana

Robert L. Haggerty 5244 Broad Street, N.W. Wash., D.C. 20015

Initial Date of Birth Sex
Joseph Lawler's Home, Inc. 6/28/86
2150 VI Ave., NW Wash., D.C. 20015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17697

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Rosemary | | MIDDLE
(nmi) | | LAST
Hajarian | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 28 86 | | 2b. HOUR
258 M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 27, 1939 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Panama | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Darnestown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
14513 Falling Leaf Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FORMOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Darnestown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
14513 Falling Leaf Drive, 20878 | | | | | |
| 14. FATHER'S NAME
James | | 15. MOTHER'S MAIDEN NAME
Idalia Arce | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-62-6541 | | 17. INFORMANT
Gerald R. Hajarian, Same as # 13. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral Brain Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Malignant Brain Tumor</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Systemic Lupus Erythematosus</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19 82</u> , to <u>June 11 19 86</u> , that (I) (we) last saw the deceased alive on <u>June 11, 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John G. Lodmell MD</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>6/28/86</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN G. LODMELL, MD | | 22e. ADDRESS
2901 Chesapeake Spring Rd. Chevy Chase, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
July 1, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Gabriels Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Potomac Montgomery Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
300 W. Montgomery Ave. Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | | | | | |

BP

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing a certain article of manufacture.

The matter is now under consideration and will be given the proper attention.

Very respectfully,
J. H. [Name]

Enclosed herewith is a copy of the report of the committee on the subject of the application for a patent for the invention of a new and improved method of producing a certain article of manufacture.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

Very respectfully,
J. H. [Name]

00-11398

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617698

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John H. Hall | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-25-86 | | | | 2b. HOUR
11:20 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 83 11 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ENGINEER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13a. COUNTY HGP | | | | 13c. CITY OR TOWN
LANDOVER | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3120 81ST AVE 20784 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT H. HALL | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA JACKSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
GENEVA HALL (WIFE) 3120-81ST AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes Mellitus
(c) Coronary Artery Disease, Aspiration Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hrs
48 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-24 , 19 86 , to 6-25 , 19 86 , that (I) (we) lost
saw the deceased alive on 6-25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Phillip W. Poth M.D. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6-26-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
831 UNIVERSITY BLVD S.E. MD 20623 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
6-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEM. BRENTWOOD | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MD | | | |
| 24. FUNERAL DIRECTOR
NAME
MODERN FUNERAL Home | | | | ADDRESS
3821-14th ST. N.W.D.C. | | 25a. DATE REC'D. BY REGISTRAR
JUL 3 - 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

00-11386

2025 COLLECTION LISTEN



100



4
00-11058STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17699
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|--|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCES E. HANSBOROUGH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 16, 1986 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 23, 1920 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | 8. IF UNDER 74 HRS
HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH
Silver Spring | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12902 Winter Thur Ln. | | 14. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Md. | | 15b. COUNTY
Montgomery | | 15c. CITY OR TOWN
Silver Spring | | |
| 16. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 17. STREET ADDRESS
12902 Winter Thur Ln. | | 18. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | |
| 19. KIND OF BUSINESS OR INDUSTRY
Shoe | | 20. FATHER'S NAME
FIRST MIDDLE LAST
Roland McCauley | | 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Jacobs | | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 23. SOCIAL SECURITY NO.
227-12-8444 | | 24. INFORMANT
Carol Blair | | |
| 25. 12902 Winter Thur La.
Silver Spring, Md. 20904 | | 26. 12902 Winter Thur La.
Silver Spring, Md. 20904 | | 27. 12902 Winter Thur La.
Silver Spring, Md. 20904 | | |
| 28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) colon cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) 18 months
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | |
| 29a. DATE OF OPERATION | | 29b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 29c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 29d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 30a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 30c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 30d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 30e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 30f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 30g. I certify that (I) (this hospital) attended the deceased from 2/5 , 19 85 , to 6/16 , 19 86 , that (I) (we) last saw the deceased alive on 4/30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 30h. SIGNATURE
Bruce A. Silver | | |
| 30i. DEGREE | | 30j. ADDRESS
106 Irving St. N.W., Washington D.C. | | 30k. DATE SIGNED
June 16, 1986 | | |
| 30l. PHYSICIAN'S NAME (TYPE OR PRINT)
Bruce A. Silver | | 30m. ADDRESS
106 Irving St. N.W., Washington D.C. | | 30n. DATE SIGNED
June 16, 1986 | | |
| 31a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 31b. DATE
June 20, 1986 | | 31c. NAME OF CEMETERY OR CREMATORY
National Memorial Park, Falls Church, Va. | | |
| 31d. LOCATION
CITY OR TOWN COUNTY STATE | | 31e. FUNERAL DIRECTOR
NAME
Money & King Vienna Funeral Home | | 31f. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | |
| 31g. 171 W. Maple Ave., Vienna, Va. | | 31h. SIGNATURE
Julia Darden-Radner | | 31i. SIGNATURE | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17700
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|--|
| DECEASED NAME
(TYPE OR PRINT) HORACE HUNN HARDING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-5-86 | | | 2b. HOUR
MIN.
3:40 A M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 19 31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept of Defense | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
104 Hamilton Avenue 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Horace Hunn Harding | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marion Kingsbury | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1951-55 | | 17. INFORMANT
Claudetta W. Harding | | ADDRESS
Wife Same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SHOCK | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hrs | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC CANCER | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CANCER 10 SITE UNKNOWN | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20 , 19 86 , to 6/5 , 19 86 , that (I) (we) last saw the deceased alive on 6/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Stanley A. Schwartz MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/5/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STANLEY A. SCHWARTZ MD | | | | | | 22e. ADDRESS
2101 Medical Park Drive Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
June 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME (TYPE OR PRINT)
Francis J. Collins, Jr.
500 University Blvd. West Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-09903

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17701

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD CHARLES HARMON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 12 1986 | | 2b. HOUR
10:15 A | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 28 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | | | 13b. CITY OR TOWN
ARLINGTON | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GOODSEL BENJAMIN HARMON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIOLA ELIZABETH SPENCE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
19-1986 | | 17. INFORMANT
ADDRESS
SYLVIA A. HARMON, 106 FLAMINGO DRIVE, SALISBURY, MD 21801 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HODGKIN'S DISEASE
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 25 , 19 86 , to JUNE 12 , 19 86 , that (I) (we) last saw the deceased alive on JUNE 12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Gustavo G.</i> | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3 JUN 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G.A. CALLEJA, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Stanford Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fruitland Wico Md | |
| 24. FUNERAL DIRECTOR
NAME
Gladys Stewart | | | | ADDRESS
West Rd Salis. Md | | 25a. DATE REC'D. BY REGISTRAR
JUN 19 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

60820-0



20250 COTTON: 60820

00-11635

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617702

REG. NO.

| | | | | | | | |
|---|--|---|--|---|----------------------|--|-------|
| 1. DECEASED NAME
(TYPE OR PRINT)
JENNIE HARRAD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 30, 1986 | | 2b. HOUR
7:30p.m. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 17, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS.
IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Convalescent Ctr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
----- | | 13a. STREET ADDRESS / ZIP CODE
8201 New Hampshire Ave. 20903 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Ginberg | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Metz | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No ----- | | | |
| 16b. SOCIAL SECURITY NO.
214-74-7471 | | 17. INFORMANT
Joe Harrad; 305 Kimblewick Dr., SSpG, Md. | | | | ADDRESS
20904 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c) -----
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | ----- |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 56 to June 86, that (I) (we) saw the deceased alive on June 30, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Robert L. Krichmar</i> M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
June 30, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. KRICHMAR, M.D. | | | | 22e. ADDRESS
7733 Alaska Avenue N.W., Wash., D.C. 20012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
7-2-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Va. | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25. DATE RECEIVED BY REGISTRAR
JUL 08 1986 | | | |
| 25. REGISTRAR'S SIGNATURE
<i>Julia Sander-Randner</i> | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of police.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

CC-11832



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

00-0982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17703

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Annie M. Horrigan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 14, 1986 | | 2b. HOUR
6:00 A.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
11 TH 22 1898 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12416 Feldon Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
12416 Feldon Street 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Moran | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna McGann | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
120-20-3521 | 17. INFORMANT
ADDRESS
Thomas J. Horrigan son Same As 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>weeks</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 11</u> , 19 <u>86</u> , to <u>June 14</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>June 11</u> , 19 <u>86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Wilfred R. Ehrmantrant | | DEGREE
MD | 22c. DATE SIGNED
6/14/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wilfred R. Ehrmantrant |
| 22e. ADDRESS
1125 Rockville Pike Rockville Md | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
June 18, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hawthorne Westchester N.Y. | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBERS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CARLTON WILLARD HARVEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-12-86 | | 2b. HOUR
8:15 P.M. | | | | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
12 13 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Sandy Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Friends Nsg. Home | | 12a. DISTRICT (NAME OF PLACE OF WORK FOR MOST OF WORKING LIFE)
Insurance | 12b. KIND OF BUSINESS OR INDUSTRY
INSURANCE | | | | | |
| 13a. STATE
md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
SANDY SPRING | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
17405 QUAKER LANE 20860 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hiram W. Harvey | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie M. Oland | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
330-019-338 | | 17. INFORMANT
ADDRESS
HELEN HAWKINS OLNEY, MD. 20832 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>PARKINSON'S DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>5 yrs.</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>TERM</u> | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> 19 <u>81</u> to <u>6/12</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/10</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | |
| 22b. SIGNATURE
<u>D. R. Lewis MD</u> | | DEGREE | | 22c. DATE SIGNED
<u>6/12/86</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. R. LEWIS MD | | 22e. ADDRESS
OLNEY, MD 20832 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | 23b. DATE
JUNE 16, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOHN'S CEMETERY | | 23d. LOCATION
OLNEY MONT. COUNTY MD. STATE | | | | | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>James Anderson</u> | | | | | |

3223022



3223022 X-60 V. COLON 10185

20-11-1964

20

1. The first part of the report is a description of the work done during the period 1.1.64 to 31.12.64. It is divided into two main sections: (a) the work done on the project as a whole, and (b) the work done on the various sub-projects.

2. The second part of the report is a summary of the results of the work done during the period 1.1.64 to 31.12.64. It is divided into two main sections: (a) the results of the work done on the project as a whole, and (b) the results of the work done on the various sub-projects.

3. The third part of the report is a summary of the conclusions drawn from the work done during the period 1.1.64 to 31.12.64. It is divided into two main sections: (a) the conclusions drawn from the work done on the project as a whole, and (b) the conclusions drawn from the work done on the various sub-projects.

4. The fourth part of the report is a summary of the recommendations made during the period 1.1.64 to 31.12.64. It is divided into two main sections: (a) the recommendations made from the work done on the project as a whole, and (b) the recommendations made from the work done on the various sub-projects.

5. The fifth part of the report is a summary of the conclusions drawn from the work done during the period 1.1.64 to 31.12.64. It is divided into two main sections: (a) the conclusions drawn from the work done on the project as a whole, and (b) the conclusions drawn from the work done on the various sub-projects.

00-09260

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17705

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph W. HAWKINS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 9, 1986 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
March 16, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
American | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bus Driver | 12b. KIND OF BUSINESS OR INDUSTRY
Public School | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Damascus | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Franklin Hawkins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Estelle Lyles | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
214-28-9105 | 17. INFORMANT
M. Marie Hawkins | | ADDRESS
Item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident with left hemiparesis</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 mo.</u> |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Cont. Chronic urinary infections, convulsive disorder</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1984</u> to <u>Jun. 9, 1986</u> that (I) (we) last saw the deceased alive on <u>Jun. 8, 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Frederick Moomau M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/9/1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederick Moomau, M.D. | | 22e. ADDRESS
2901 Olney Sandy Spring Rd., Olney, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/13/86 | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Grove Ceme. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Purdim, Montg. Md. |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Damascus, Md. | | | 25a. DATE REC'D. BY REGISTRAR
JUN 12 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>Jana Davidson Randall</u> | | |

00-02524

| | | |
|-----------------|-----------------------------|-----------------|
| June 2, 1988 | HAWKINS | Joseph |
| March 16, 1903 | March 16, 1903 | March 16, 1903 |
| Montgomery Co. | American | Irishland |
| Public School | Montgomery General Hospital | Quincy |
| 1987 | 1987 | 1987 |
| 11800 Price St. | 11800 Price St. | 11800 Price St. |
| Lydia | Franklin Hawkins | Joseph |
| 11800 Price St. | 11800 Price St. | 11800 Price St. |
| 11800 Price St. | 11800 Price St. | 11800 Price St. |

x

6/9/1988

Frederick Monahan, N.Y.

2001 Quincy Sandy Spring Rd., Quincy, Md.

6/13/88 Pleasant Grove Cere. Turbur. Mont. Md.

Old L. Holmworth, N.Y., Danvers, Md.

5
00-100851- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17706

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HONTERTAL HENDERSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 18, 1986 | | 2b. HOUR
M
M | |
| 3 SEX
FEMALE | | 4 RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 3, 1943 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
UPPER MARLBORO | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12408 STURDEE DR. | | 12a. USUAL OCCUPATION
(OF WORK FOR MOST OF WORKING LIFE)
Secretary | |
| 12b. KIND OF BUSINESS OR INDUSTRY
NH | | 13a. STREET ADDRESS / ZIP CODE
12408 STURDEE DR. 20772 | | 13b. CITY OR TOWN
UPPER MARLBORO | |
| 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Lyons | | 14. INFORMANT
NAME ADDRESS
MR. WILLIAM HENDERSON 12408 Sturdee Dr (HUSBAND) | |
| 15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EXTENSIVE METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
414-64-1327 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21a. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 31 , 19 85 , to JUNE 18 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 16 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> not view the body after death. | | 22b. SIGNATURE
Cy Stein | | 22c. DATE SIGNED
6/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cy Stein | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD 20892 | | 22f. DATE REC'D. BY REGISTRAR
JUN 20 1986 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis AA Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm Reser Sons - Annapolis, Md | | 25a. DATE REC'D. BY REGISTRAR
JUN 20 1986 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, removal of the body should be reported at once.

00-08753

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17707
REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) MILDBED | | FIRST HERMAN | | LAST | | 2a. DATE OF DEATH
MONTH 6 DAY 2 YEAR 86 | | 2b. HOUR 8:40 P | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 9 DAY 26 YEAR 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOMEMAKER | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6121 MONTROSE RD. ROCKVILLE, MD. (20852) | | | |
| 14. FATHER'S NAME
FIRST NATHAN MIDDLE OSCHER LAST OSCHER | | 15. MOTHER'S MAIDEN NAME
FIRST MINNIE MIDDLE LUBIN LAST LUBIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
059-52-2914 | | 17. INFORMANT
7112 N. Broad St. Phila., Pa. (19126)
Joseph Levine & Son Mem. Chapel | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Patient was dead on arrival to Suburban Hospital from the Hebrew Home
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-2 , 19 86 , to 6-2 , 19 86 , that (I) (we) lost saw the deceased above , (I) (we) (did) (did not) view the body after death, 19 , and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
Philip Schwartz MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6-3-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP SCHWARTZ | | 22e. ADDRESS
Hebrew Home - Montrose Rd, Rockville, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY
MONTEFIORE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKLEDGE, PA. | | | | | |
| 24. FUNERAL DIRECTOR
NAME SOI LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | | 25a. DATE REC'D. BY REGISTRAR
JUN 6 1986 | | 25b. REGISTRAR'S SIGNATURE
Jane Gordon | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," the medical examiner must be notified at once.

RELEASED BY ME

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



Office of the Director
Bureau of Plant Industry
Washington, D. C.

Very respectfully,
[Signature]

[Signature]
[Name]

00-08773

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617708
REG. NO.

| | | | | | | | |
|---|--|--|--|---|----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
IRMA T. HICKMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 3 1986 | | 2b. HOUR
220 P.M. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 7 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
WASHINGTON DC | | 13b. COUNTY
D.C. | | 13c. CITY OR TOWN
D.C. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WALLACE TRAVIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA A STAMPS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-60-5364 | |
| 17. INFORMANT
JEAN W. HICKMAN | | 18. ADDRESS
710 WHITTIER ST. NW | | 19. STREET ADDRESS / ZIP CODE
710 WHITTIER ST. NW | | 20. CITY OR TOWN
WASHINGTON DC | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF <u>CONGESTIVE HEART FAILURE</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>PULMONARY EMBOLISM, HYPERTENSIVE AND ARTERIO-SCLEROTIC HEART</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 19 70</u> to <u>JUNE 3 19 86</u> , that (I) (we) last saw the deceased alive on <u>JUNE 3 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Robert L. Krichmar MD</u> | | 22c. DATE SIGNED
JUNE 3 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. KRICHMAR MD | | 22e. ADDRESS
7733 ALASKA AVENUE NW
WASHINGTON DC 20012 | | 22f. DEGREE
MD | | 22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |

| | | | | | | | |
|---|--|---|--|---|--|-------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
JUNE 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Olinston National | | 23d. LOCATION
Olinston. VA | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home, Takoma Park, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 6 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 should be any injury, or other traumatic event, the medical examiner should be notified at once.

BP

 999999
 BIRTH: 10:00M 7/84
 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-09553

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|---------------|-------------------|--|--|-------------------------|--|---|----------------|------------------|--|---|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| DIANA | | | Queen | | | HIGHTRINK | | | 6 9 1986 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | | Viet-
Name | | 1-19-1986 | | YRS. 4 | | MONTHS 20 | | HOURS | | 6 9 86 | | 5:16 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | United States | | | | | | | | Montgomery, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | | | Holy Cross Hospital | | | | None | | | | N/A | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | Montgomery | | | | Silver Spring | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| 4023 Ferrara Drive / 20906 | | | | Vanhdalone Kingkeo | | | | no | | | | none | | | |
| 17. INFORMANT | | | | 17. ADDRESS | | | | 17. ADDRESS | | | | 17. ADDRESS | | | |
| Twee Hightrink, | | | | Same as 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a). <u>Sudden Infant Death Syndrome</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b). <u></u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c). <u></u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| | | | | Assistant | | | | 6/10/86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Gregory Kauffman, M.D. | | | | 111 Penn St., Baltimore 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Cremation | | | | June 11, 1986 | | | | Metropolitan Crematory | | | | Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Richard Rapp, Inc. | | | | JUN 16 1986 | | | | | | | | | | | |
| 1804 T Street, NW, Washington, DC 20009 | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE CHIEF, MEDICAL EXAMINER, AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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BP
DHMH - 17
(VR A15 ME (5))

Page 1

Received from the U.S. Department of the Interior

Marshall Islands

Marshall Islands

Marshall Islands

Marshall Islands

Marshall Islands

Marshall Islands

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17710
REG. NO.

| | | | | | |
|---|--|--|---|---------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. HOUR | |
| Juanita F Hoke | | | | 6/26/86 0923 ^{AM} | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | white | 03 31 17 | 69 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| W. VA | USA | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Jakoma Park | Washington Adventist | | Self employed | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| md. | M.C. | Beltsville | 13e. STREET ADDRESS / ZIP CODE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 3108 Ellicott Road 20705 | | |
| Jacob Heishman | Virda Bean | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| N/A | N/A | 213-202731 Dennis Hoke (Son) Same as 13E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>anything</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>mitral valve prolapse</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>anemia, hepatomegaly</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 30</u> , 19 <u>86</u> , to <u>June 26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | June 26, 1986 | | | |
| Michael A. Pesken | W.A.H. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 6-30-1986 | Asbury Cemetery | Baker | W. Va. | |
| 24. FUNERAL DIRECTOR | 11800 New Hamp Ave. | | 25a. DATE REC'D. BY REGISTRAR | | |
| Hines/Rinaldi Funeral Home | Silver Spring, Md. 20904 | | JUN 27 1986 REGISTRAR'S SIGNATURE | | |

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00-09069

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17711

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Margaret E. Holland | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-6-86 | | 2b. HOUR
11:17 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
YEAR
JUNE 22, 1916 | |
| 6. BIRTHPLACE (STATE OR FOREIGN)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. AGE (IN YEARS LAST BIRTHDAY)
69 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF DECEASED IN A NURSING HOME, GIVE NAME OF NURSING HOME)
ROCKVILLE NURSING HOME | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
GOV. | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY
MD. MONT. GAITHERSBURG | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN - CROSS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY - MAUS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
579-01-92 69 | | 17. INFORMANT
ADDRESS
GARY HOLLAND SAME AS #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) end stage COPD
DUE TO, OR AS A CONSEQUENCE OF
(c) lung disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
five years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8 , 19 86 , to 6/6 , 19 86 , that (I) (we) last saw the deceased alive on 6/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Franke Westphal MD | | DEGREE
ATTENDING PHYSICIAN | | 22c. DATE SIGNED
6/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. FRANKE WESTPHAL | | 22e. ADDRESS
809 Veirs Mill Rd. Rockville, Md. 20850 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JUNE 11, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT. MD. | | 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 10 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B above, any injury, or other traumatic event, the medical examiner's name must be filled in on item 17.

Mr. J. H. ...
Holliston



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17 / 12

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCES - HOLLIDAY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 23 1986 | | 2b. HOUR 12 MIN 26 | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 27 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mo. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Education | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Orlando Breckenridge Holliday | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth - Lee | | 13e. STREET ADDRESS / ZIP CODE
403 Russell Ave. #109 | | 20877 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
508-40-6900 | | 17. INFORMANT
(#611) ADDRESS
Dorothy Culver Gaithersburg, Md. 20877 | | 407 Russell Ave., | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asystole
DUE TO, OR AS A CONSEQUENCE OF
(b) A.S.H.D. - Chr. C.H.F.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Anemia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 7-6 to 6-23 86 , that (I) (last saw the deceased alive on 6-21 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jack Schumacher M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6-23-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Schumacher, M.D. | | | | 22e. ADDRESS
105 Russell Ave., Gaithersburg, Md. 20877 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 26 1986 | | 25b. REGISTRAR'S SIGNATURE
John E. ... | |

BP

00-08796

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17713
REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY ELIZABETH Holmes | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 2, 1986 | | 2b. HOUR
7:45 PM |
| 3. SEX
FEMALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4-22-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
OHIO | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GROS VENEUR HEALTH CARE CT | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4707 ADRIAN St 20755 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony Owens | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nettie Hemperly | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-01-4509 | | 17. INFORMANT
Derwood, Maryland 20855
Nancy Simpkins 17510 Sabrina Terrace | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c) ycm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Arteriosclerosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29/86 to 6/2/86 , that (I) (we) lost
saw the deceased alive on 5/29/86 and that (I) (we) gave opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thos G. Ward M.D. | | DEGREE | | 22c. DATE SIGNED
6/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. WARD, M.D. | | 22e. ADDRESS
Rockville, Bethesda 20817 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/4/86 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland 20852 | | | 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
John S. Anderson | | |

BP
DHMH - 16 50M 4/82
(VRS 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The following information is for your information only:

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

001103001

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 7 1 4

| | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James E. Honaker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 23 86 | | | 2b. HOUR
9:55 P.M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 10 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Security | | 12b. KIND OF BUSINESS OR INDUSTRY
Vitro Corp. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Adelphi | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7941 18th Ave 20783 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph A. Honaker | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle E. Shrader | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
WW11 | | 17. INFORMANT
ADDRESS
Helen I. Honaker-wife-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Renal failure, Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary artery bypass graft-</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Severe coronary artery disease, COPD</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>5/20/88</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Severe coronary artery</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/20/86</u> , 19 <u>86</u> , to <u>6/23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Gita C. Bashi</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>6/24/88</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>GITA C. BASHI</u> | | | | | | 22e. ADDRESS
<u>WASHINGTON ADVENTIST HOSPITAL</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>6-26-1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rocky Hill Cemetery</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Woodsboro Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hines/Rinaldi Funeral Home</u> | | | | | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
<u>JUN 24 1986</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0011300

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "SINCE" and "ON" are visible.]

0011300

10-10237

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17715

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANNA M HOSS | | | 2a. DATE OF DEATH
MONTH 6 DAY 19 YEAR 86 | | | 2b. HOUR
3:55 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 10 DAY 07 YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10621 Glenwild Road 20901 | | | |
| 14. FATHER'S NAME
FIRST Thomas MIDDLE LAST Gergella | | | | 15. MOTHER'S MAIDEN NAME
FIRST Amalia MIDDLE LAST Fuchs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
261-07-4002 | | 17. INFORMANT
ADDRESS
Margaret P. Damare Daughter Same as 13 | | | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Basilar ulcer, with hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN CAUSE AND DEATH
18 hrs.
4 days | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 22 19 86 , to June 19 19 86 , that (I) (we) last saw the deceased alive on June 19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE
Raymond Bradshaw, MD | | | | DEGREE
MD | | 23b. DATE SIGNED
6/19/86 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond Bradshaw, MD | | | | 23d. ADDRESS
345 University Blvd. W
Silver Spring, Md. | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
June 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Jacksonville Evergreen Florida | |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins, Jr.
ADDRESS 500 University Blvd. West Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Hendell | |

00-10238

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as 18, a medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 1 1 6

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LILLIE Mary HOWARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-16-86 | | 2b. HOUR
1:27 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4-1-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Pr. Geo. Mt. Rainier | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Corder | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-12-0245 | | 17. INFORMANT
Friend ADDRESS
7804 Lockney Avenue
Agnes Marie Salter Takoma Park, Md. 20912 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema, Caputite Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, Pneumothorax, Cardiac arrest
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION
6/16/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Tracheostomy + Gastrostomy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27/86 , 19____, to 6/15/86 , 19____; that (I) (we) lost
saw the deceased alive on 6/14/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VIVER C VAID | | 22e. ADDRESS
3311 Taledo Terrace # B102 Hyattsville | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd., W. Silver Spring, Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

00-12212

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17717

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ricky Lee Hurst | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06/27/86 | | 2b. HOUR
8:00p | | |
| 3. SEX
male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 27 86 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
1 59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wheaton | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3351 Hewitt Avenue 20902 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Don Telfer, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Lee Hurst | | 16. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Don Telfer, Jr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Preexisting Delay at Home of
DUE TO, OR AS A CONSEQUENCE OF Preexisting Delay
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Preexisting Delay
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. J. Young | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-27-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ali Young | | 22e. ADDRESS
M G H | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
July 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 11 1986 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is completed, the medical examiner must be notified of the death.

[Faint circular stamp]

2000

2. 2003.12.14

500 - University of Illinois, Urbana, Illinois

10-08112

HUNT

10-08112

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10-08112

00-11148

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17719
REG. NO.

| | | | | | | |
|---|--|---|--|--|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT EARL IFFERT, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-30-86 | | 2b. HOUR
8:30 AM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 28, 1899 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS (LAST BIRTHDAY))
86
YRS MONTHS DAYS | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARRIAGE HILL-BETHESDA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Educator | | 12b. KIND OF BUSINESS OR INDUSTRY
Federal Gov't. | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5308 Huntington Parkway 20814 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Iffert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Evalena Waggaman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None 579-58-1349 | | 17. INFORMANT
ADDRESS
Jean T. Iffert, Wife, 5308 Huntington Parkway Bethesda, Md. 20814. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Metastatic Carcinoma of the bladder</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/25/86</u> 19 <u>86</u> to <u>6/30/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/26/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 27b. SIGNATURE
<u>R. Shakir</u> | | DEGREE
<u>MM</u> | | 27c. DATE SIGNED
<u>6/30/86</u> | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>RAMLETH SHAKIR</u> | | 27e. ADDRESS
<u>6001 Lux Lane Rockville MD 20859</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
July 1, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Cty., Maryland | | 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS CO., 8655 Georgia Ave., S.E. 20910
ADDRESS
W. W. CHAMBERS CO., 8655 Georgia Ave., S.E. 20910
M.D. | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. W. Jordan</u> | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Page 1 of 1

| Name | Age | Sex |
|---------------|-----|-----|
| John Doe | 25 | M |
| Jane Smith | 30 | F |
| Bob Johnson | 28 | M |
| Alice Brown | 22 | F |
| Charlie White | 35 | M |
| Diana Green | 27 | F |
| Eve Black | 32 | F |
| Frank Gray | 29 | M |
| Grace Hall | 24 | F |
| Henry King | 31 | M |
| Ivy Lee | 26 | F |
| Jack Miller | 33 | M |
| Karen Wilson | 23 | F |
| Leo Young | 34 | M |
| Mia Adams | 21 | F |
| Noah Baker | 36 | M |
| Olivia Clark | 20 | F |
| Peter Davis | 37 | M |
| Quinn Evans | 25 | F |
| Samuel Foster | 38 | M |
| Tina Gibson | 24 | F |
| Uma Harris | 26 | F |
| Victor Ives | 39 | M |



Handwritten notes at the bottom of the page, including a signature and date.

00-09517

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17720

| | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---------------|--|--|--|----------------------------|--|--|--|--------------------------|--|---|--|------------------|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Louis | | MIDDLE T. | | LAST Iglehart, Jr. | | 2a. DATE KNOWN OF DEATH | | X MONTH 6/12 | | DAY 19 | | YEAR 86 | | 2b. HOUR | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR | | Oct. 21, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | 6/12 19 86 | | 7d. HOUR P. 6:00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Kentucky | | | | United States | | | | | | | | Montgomery County MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK AT MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | | | 2213 Georgian Way, #23 | | | | Writer/Producer | | | | Film | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Montgomery | | | | Silver Spring | | | | 20902 | | | | 2213 Georgian Way, #23 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| Louis T. Iglehart, Sr | | | | Elizabeth Morgan | | | | Yes | | | | 1946-1953 | | | | 420 18 7903 | | | |
| | | | | | | | | | | | | Clayton D. Iglehart | | | | ADDRESS 909 Sligo Creek Pkwy. Takoma Park, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute myocardial disease. | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| Alcoholism | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| None | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| | | | | P.M. 19 | | | | None | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | | | COUNTY | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | MEDICAL EXAMINER | | | | DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | 6/13/86 | | | | | | | |
| John S. Rogers, M.D. | | | | 1919 Seminary Road | | | | | | | | | | | | | | | |
| | | | | Silver Spring, Montgomery County, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | | COUNTY | | | |
| Cremation | | | | June 13, 1986 | | | | Metropolitan Crematory | | | | Alexandria, Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Robert A. Pumphrey | | | | JUN 16 1986 | | | | | | | | | | | | | | | |
| 7557 Wisconsin Ave. Bethesda, MD 20814 | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
OHMH - 17
(VR A15 ME (5))

1130-500

RECEIVED

575

7

00-08583

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17721

REG. NO.

| | | | | | |
|---|------------------|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EVELYN C. JACKSON | | MONTH DAY YEAR
JUNE 2 86 | | 6:05 P.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 12, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARRIAGE HILL BETHESDA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | |
| 13a. STATE
NY | | 13b. COUNTY
Nassau | | 13c. CITY OR TOWN
Hewlett | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Everitt -- Cornell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Abigail -- Pryor | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
119-01-0754 | | 17. INFORMANT
10907 Clermont Ave.
Janice Calvert, Garret Park, MD 20896 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ARTEROSCLEROTIC CEREBROVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-5</u> , 19 <u>85</u> to <u>6/2/</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6/2/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Richard H. Bowen</u> | | DEGREE
MD | | 22c. DATE SIGNED
6/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard H. Bowen MD | | 22e. ADDRESS
10400 G. Neck Road
Alexandria, VA | | 22f. ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Crematory | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, VA | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | 25a. DATE REC'D. BY REGISTRAR
JUN 5 1986 | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 contains injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

00-11149

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 51. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17122

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Ruby Bertina Jackson</i> | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED
MONTH DAY YEAR
<i>June 26, 1986</i> | | 2c. HOUR
AM PM
<i>12:00 AM</i> | | | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>BLK</i> | | 5. DATE OF BIRTH (MONTH DAY YEAR)
<i>April 22 33 53 YRS.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>53 YRS.</i> | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2d. DATE PRONOUNCED DEAD
MONTH DAY YEAR
<i>June 26 1986</i> | | 2e. HOUR
AM PM
<i>8 AM</i> | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>VIRGINIA</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Tak Park</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Wash. Sch. Hlth</i> | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>20912</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>MD Montg Tak Park</i> | | | | 13b. CITY OR TOWN
<i>Tak Park</i> | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS
<i>7603 Eastern Ave Apt 101</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Corel Butler</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>MARY MAITH</i> | | | | 16. SOCIAL SECURITY NO.
<i>204-38-3643</i> | | | | | | | | 17. INFORMANT ADDRESS
<i>IRENE VENEY 6137 Leesburg Pike Falls Church VA</i> | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
<i>NO</i> | | | | 18b. SOCIAL SECURITY NO.
<i>204-38-3643</i> | | | | 18c. SOCIAL SECURITY NO.
<i>204-38-3643</i> | | | | | | | | 18d. SOCIAL SECURITY NO.
<i>204-38-3643</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
<i>None</i> | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>J. S. Rogers</i> | | | | TITLE (SPECIFY)
<i>M.D.</i> | | | | MEDICAL EXAMINER
<i>Dog</i> | | | | DATE SIGNED
<i>June 26 1986</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
<i>J. S. Rogers</i> | | | | ADDRESS | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | | 23b. DATE
<i>7-1-86</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lively Hope Cemetery</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Thurmont MD NT Thurmont VA</i> | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>H.W. Chambers F.H.</i> | | | | ADDRESS
<i>517-11th St SE Wash DC</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JUL 2 1986</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>John A. Anderson</i> | | | | | | | |

2009 COLLEGE BIPED

12/17/09



12/17/09

00-09351

12

49
88
35
120
1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 2 3

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | June 4, 1986 | | | 4:25p.m. | | | |
| 3. SEX Male | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. AGE (IN YEARS LAST BIRTHDAY) 82 | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE 12b COUNTY 12c CITY OR TOWN Maryland Montgomery Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 8201 16th Street, #209 (20910) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louie Jaffe | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Abramovitz | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 577-10-5760 | | | 17. INFORMANT ADDRESS Silver Spring, Md. 20910 | | | Ann Helen Jaffe; Wife; 8201 16th St., #209; | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lymphocytic Leukemia | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2d
3d
13 yrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Urinary tract infection, Diarrhea | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 5/22/86 to 6/4/86, that (ii) we last saw the deceased alive on 6/4/86, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (ii) we did (and not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Peter B. Sherer | | | | | | DEGREE MD | | 22c. DATE SIGNED June 5, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER, M.D. | | | | | | 22e. ADDRESS 3947 Ferrara Drive; Wheaton, Md. 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (1) Burial | | | 23b. DATE 6/6/86 | | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va. | | | 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | JUN 10 1986 | | | John A. ... | | | |

1. The first part of the report is a summary of the work done during the last year. It is a very brief summary, but it gives a good idea of the work that has been done. It is a very good summary, and it is a very good idea to have a summary of the work done during the last year.

2. The second part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

3. The third part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

4. The fourth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

5. The fifth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

6. The sixth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

7. The seventh part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

8. The eighth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

9. The ninth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

10. The tenth part of the report is a description of the work done during the last year. It is a very detailed description, and it gives a good idea of the work that has been done. It is a very good description, and it is a very good idea to have a description of the work done during the last year.

35
00-11798

249
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17724

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROCHELLE (NMN) JAGENDORF | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 28, 1986 | | 2b. HOUR
P M
2:05 P |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 2, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NTH. THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
TENNESSEE | | 13b. COUNTY
Shelby | 13c. CITY OR TOWN
MEMPHIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
306 SHADY WOODS COVE 38119 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALLIE ALTMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MILDRED JACKSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b. SOCIAL SECURITY NO.
321-14-6446 | | 17. INFORMANT
ADDRESS
GARY M. COLE, SON 22 PERSIDIO AVE SAN FRANCISCO, CA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Idiopathic hypertrophic subaortic stenosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Mitral and Aortic valvular disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
Systemic Lupus | | | | | |
| 19a. DATE OF OPERATION
6/12/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LVOT Obstruction
Aortic & Mitral Insufficiency | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 12 , 19 86 , to June 28 , 19 86 , that I (we) last saw the deceased alive on JUNE 28 , 19 86 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Francisco A. Arabia | | DEGREE
MD | | 22c. DATE SIGNED
6/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRANCISCO A. ARABIA | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD. 20892 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
7-1-1986 | 23c. NAME OF CEMETERY OR CREMATORY
Westlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Norwood park, Illinois |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | ADDRESS
Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JUL 02 1988 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the notified surgeon.

CHIEF WAGON

RECEIVED

000-08724

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17725

| | | | | | |
|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Elsie</u> MIDDLE <u>M</u> LAST <u>Johns</u>
<u>John</u> | | 2a. DATE OF DEATH
MONTH <u>6</u> DAY <u>2</u> YEAR <u>86</u> | | 2b. HOUR
<u>3:50</u> A.M. | |
| 3. SEX
<u>F</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH <u>6</u> DAY <u>18</u> YEAR <u>91</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>94</u> YRS. | 7. IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington D.C.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Takoma Park</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Washington Adventist Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>Montgomery</u> | 13c. CITY OR TOWN
<u>Takoma Park</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>William</u> MIDDLE <u>Sharswood</u> LAST <u></u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Estelle</u> LAST <u>Kaufmann</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>577 38 3691</u> | | 17. INFORMANT
ADDRESS
<u>Mrs Myrtle Longo, 1020 East West Highway</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 Days</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>(c) sided Hemiplegia 20 CVA -</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>86</u> , to <u>6-2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6-1</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, view the body after death.) | | | | | |
| 22b. SIGNATURE
<u>David Cromwell</u> | | DEGREE
<u>ATTENDING PHYSICIAN</u> | | 22c. DATE SIGNED
<u>6/2/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DAVID CROMWELL</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>June 4, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood</u> | |
| 23d. LOCATION
CITY OR TOWN
<u>Washington</u> | | STATE
<u>D.C.</u> | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Harry H Witzke & Family Funeral Home Inc.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JUN 6 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. H. Davidson-Randall</u> | |

1175

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-10754

1962 COLTON FILE

100-10754

100-10754



100-10754

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17126

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|----------------------|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles A. Johnson | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR June 17 1986 | | 2b. HOUR OF DEATH
M 10 P 15 | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR July 10 1925 | | 6. AGE (IN YEARS)
YRS. 60 | | IF UNDER 1 YR
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR June 17 1986 | | 7d. HOUR
M 10 P 15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 11. CITY OR TOWN OF DEATH Sil. Spg. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK)
(MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Sil. Spg. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1400 Kenwood Lane #719 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Marcellus Riggs | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Lillie Mae Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. 218-56-3124 | | 17. INFORMANT
ADDRESS 18101 Jerusalem Ch. Poolsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Airway Obstruction
DUE TO, OR AS A CONSEQUENCE OF
(c) Food | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Cerebral Palsy | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 6:17 1986 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Choked on piece of bologna | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Bushy Dr. Sil. Spg. Montg. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) Dep. | | | | MEDICAL EXAMINER | | | | DATE SIGNED June 17 1986 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Montg. MD | | | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden | | | | ADDRESS Rockville, MD | | | | 25a. DATE REC'D. BY REGISTRAR JUN 23 1986 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))

REBEL NOTION CO. 20% COTTON FIBER



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Marshall's Ridge" and "No" are partially visible.]

0-0982-1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

17727

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Edwmetta M. Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-13-86 | | | 2b. HOUR
9:30 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-04-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
May Miller | | 13e. STREET ADDRESS / ZIP CODE
3510 Nimitz Rd. 20895 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215 44 4541 | | 17. INFORMANT
Husband ADDRESS
James F. Johnson same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) STROKE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/13 , 19 86 to 6/13 , 19 86 , that (I) (we) lost the deceased above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark H. Gog, M.D. | | | | DEGREE
MD | | 22c. DATE SIGNED
6/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark H. Gog, M.D. | | | | 22e. ADDRESS
9801 Georgia Ave., Silver Spring, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Va. | |
| 24. FUNERAL DIRECTOR
NAME
Francois I. Collins, Jr | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | | 25b. REGISTRAR'S SIGNATURE
Johanna Davidson-Randall | |

BP

00-10957

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 2 8

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PATRICIA ANNE JOHNSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 24 1986 | | 2b. HOUR
4:43 A | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 19 1937 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
Naval Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
Temporary Services | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Thornton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Davis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
577-52-6900 | |
| 17. INFORMANT
HARVEY G. JOHNSON | | 18. ADDRESS
3952 BEL PRE ROAD, SILVER SPRING, MD 20906 | | 19. STREET ADDRESS / ZIP CODE
3952 BEL PRE ROAD #7 20906 | | 20. DATE OF OPERATION
JUNE 11 1986 | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

| | | | |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION
JUNE 11 1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|---|--|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 11 1986 , to JUNE 24 1986 , that (I) (we) lost saw the deceased alive on JUNE 24 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
M. Pierdinock | | 22c. DATE SIGNED
24 JUN 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. PIERDINOCK, LCDR, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
June 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
| 7557 Wisconsin Ave. Bethesda, Maryland 20814 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2014

00-10916

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17729

REG. NO.

| | | | | | | | |
|---|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Leon W. Jones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 22 86 | | 2b. HOUR
10:02AM | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 27 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired U.S. Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Clarksville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Loveless | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
M's Dorothy F. Jones 11922 Simpson Rd 21029 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous cell carcinoma, skin, with metastasis
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Duodenal ulcer disease. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 19 85 to 6/22 86 , that (I) (we) last saw the deceased alive on 6/22 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald E. Dillman, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
22 June 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillman, M.D. | | | | 22e. ADDRESS
Olney, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 25, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlanw Gardens | | 23d. LOCATION
CITY OR TOWN STATE
Howard Maryland | |
| 24. FUNERAL DIRECTOR NAME
Harry H Witzke & Family Funeral Home | | | | 25. DATE RECEIVED BY FUNERAL HOME
JUN 30 1986 | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Inc. 4112 Old Columbia Pike Ellicottcity | | | | 25. DATE RECEIVED BY FUNERAL HOME SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be explained by the attending physician on page 4.

BP



0-10287

3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

BP _____

DHMH - 16 60M 7/84
(VRS 1, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17730

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GEORGE LEE JORDAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 18, 1986 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
9 22 34 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Takoma Park | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JASPER JORDAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary L. Bright | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-96-1151 | | 17. INFORMANT
ADDRESS
Mabel Jordan - 4009 Warner Ave
Landover Hills, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/17 , 19 86 , to 6/18 , 19 86 , that (I) (we) last saw the deceased alive on 6/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Antonio G. Uy | | DEGREE
M.D. | | 22c. DATE SIGNED
6/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANTONIO G. UY M.D. | | 22e. ADDRESS
831 Univ. Blvd E. #25 S.S. Md 20903 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. Cem | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Pr. Geo Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
George R. Snowden Rockville, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Snowden-Randall | | | |

MEDICAL CERTIFICATION

10-10-51

(4)

George Lee
Male
Wash. D.C. U.S.A.
MONTGOMERY

Taken from Washington Adventist Hospital

Mr. Monty Jackson
at Camp A. Lewis

Handwritten notes and signatures, including "Taster Jackson" and "No."

Handwritten signature or initials

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 3 1

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LEO L JORDAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 26 86 | | 2b. HOUR
MIN.
4 30 A |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
12 7 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Refrigeration Mech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Reserve Build |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Germanstown | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer J Jordan | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine A Jones | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WW II 577-05-4338 | 17. INFORMANT
ADDRESS
Mary Belle Jordan Wife Same As 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Coronary artery disease; Carcinoma Colon | | | | | |
| 19a. DATE OF OPERATION
6/13/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Left Lung | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6/25/86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12/86 19 86 , to 6/26/86 19 86 , that (I) (we) last saw the deceased alive on 6/25/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry J. Levin, MD | | DEGREE
MD | | 22c. DATE SIGNED
6/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY J. LEVIN, MD | | 22e. ADDRESS
4801 MASS AVE, N.W. WASH DC 20016 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | 23e. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | 25. REGISTRAR'S SIGNATURE
W. M. ... | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

00-15671

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

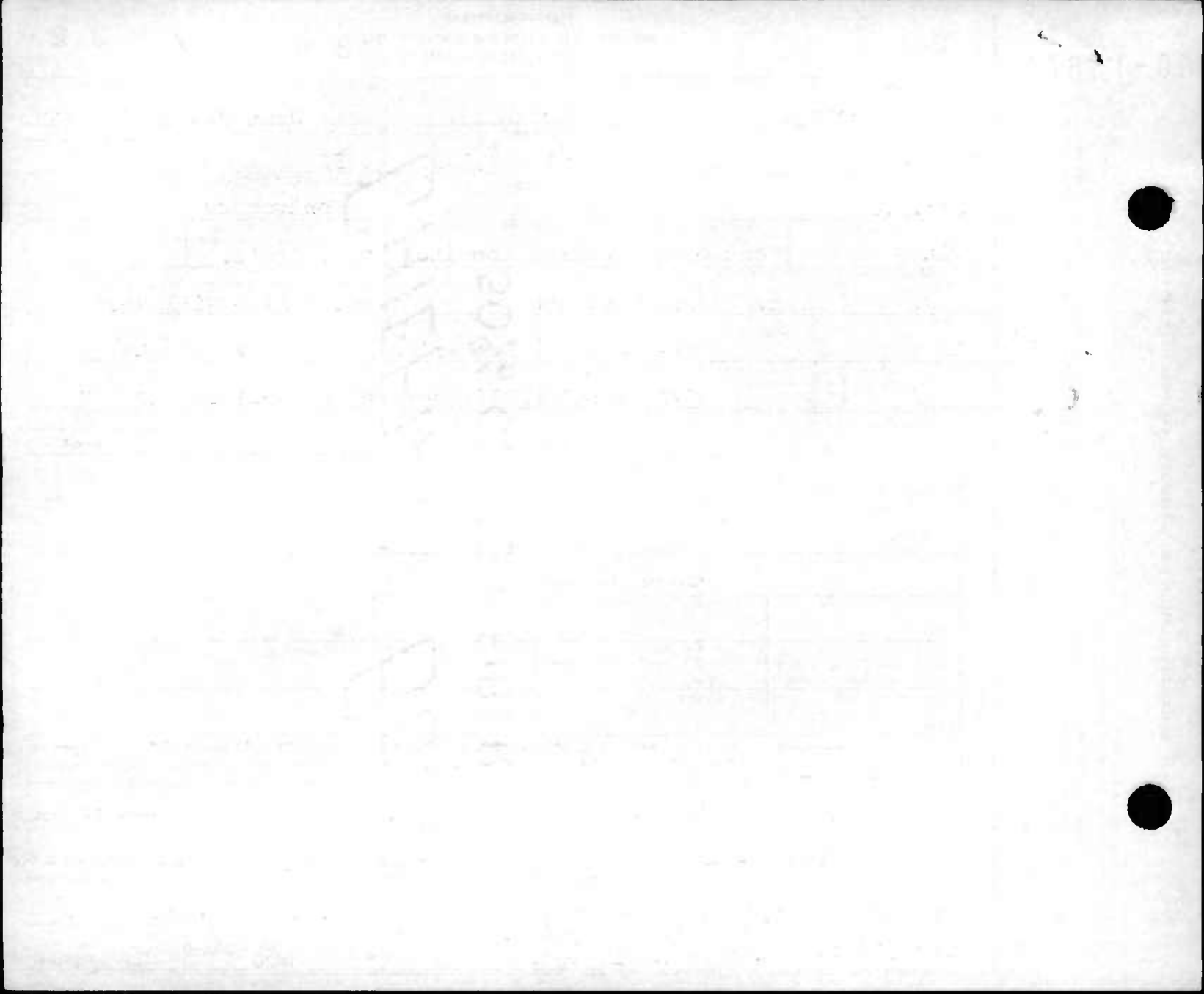
8 6 1 7 7 3 2

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Georgia C. Joseph | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 24, 1986 | | 2b. HOUR
7:45 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 8, 1933 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Wash.D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Fed. Gov't. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Christakos | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Paulmemoka | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
579 44 5010 | | 17. INFORMANT
ADDRESS
Ellis Joseph (Husband) Same as 13E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
HEPATIC CIRRHOSIS | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 20 , 19 86 , to June 24 , 19 86 , that (I) (we) last saw the deceased alive on June 24 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Barry Hecks | | | | 22c. DATE SIGNED
June 25, 1986 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECKS | | | | 22e. ADDRESS
3941 FERRARA DRIVE WHEATON, MARYLAND 20912 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/28/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
S.S. Mont. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi 11800 New Hamp.Ave.
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 27 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Julian Davidson</i> | | | | | | |

MEDICAL CERTIFICATION



00-09070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 check any injury, or other traumatic event, the medical examiner must be notified of cases.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 3 3
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
<small>(LAST OR FIRST)</small>
Katie B. Kaitis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jun. 7 1986 | | 2b. HOUR
2 A M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 28, 1923 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4705 Flower Valley Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | 12b. KIND OF BUSINESS OR INDUSTRY
Motel | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4705 Flower Valley Drive/ 20853 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Karangelen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dimetra Not Available | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 16 7885 | 17. INFORMANT
ADDRESS
Michael L. Kaitis (husband) Same as #13. | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs. |
|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Oct.</u> 19 <u>85</u> , to <u>Jun. 7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Apr. 14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Jules R. Ladisch, M.D.</u>
<u>Frederick Moomau, M.D.</u> | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6-8-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederick Moomau, M.D. | | 22e. ADDRESS
2901 Olney Sandy Springs Road, 20832 Olney Md. | | | |

| | | | |
|--|-------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1986 | 23c. NAME OF CEMETERY OR CREMATORY
Annunciation G/O Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | 25a. DATE REC'D. BY REGISTRAR
JUN 10 1986 | |
| Homes, P.A. 300 W. Montgomery Ave. Rockville Maryland | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | |

05000-00



20th Century Fund

1914-1915

00-10425

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RAYMOND KALTENBRONN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 14 86 | | | | |
| 3. SEX
MALE | | | | | 4. RACE
WHITE | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR
08 06 09 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSPITAL | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | | | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | | | |
| 13c. CITY OR TOWN
SILVER SPRING | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS / ZIP CODE
3484 Chiswick Court 20906 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
UNKNOWN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
UNKNOWN | | | | | 16b. SOCIAL SECURITY NO.
491-14-5113 | | | | |
| 17. INFORMANT ADDRESS
Michael Levine P.O. Box 995 Baltimore MD, 21203 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Cerebrovascular accident | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-30 19 86 , to 6-14 19 86 , that (I) (we) last saw the deceased alive on 6-14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Marian Chung M.D. | | | | | 22c. DATE SIGNED 6-14-86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARIAN CHUNG | | | | | 22e. ADDRESS
3701 Resmoor Blvd. Silver Spring, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Removal | | | | | 23b. DATE
6-17-86 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Med Sch | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR Columbia Mortuary Services | | | | | 25. DATE REC'D. BY REGISTRAR (SIGNATURE)
JUN 23 1986 | | | | |
| NAME ADDRESS
225 Missouri Ave, NW Washington, DC 20011 | | | | | | | | | |

00-10404

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617735

| | | | | | |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Yertrude</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>6 17 86</i> | | 2b. HOUR <i>12³⁵ PM</i> | |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>12 19 02</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sylvan Manor Health Care Center</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i> | |
| 13a. STATE <i>Maryland</i> | 13b. COUNTY <i>Pr. George</i> | 13c. CITY OR TOWN <i>New Carrollton</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Noachs</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dora Shapiro</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>065-40-4894</i> | | 17. INFORMANT ADDRESS <i>Ruth Klein; Daughter; 5913 87th Ave.; New Carrollton, Md. 20784</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-----</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i> <i>yes</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <i>Gastrointestinal bleeding</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 85</i> to <i>June 86</i> , that (I) (we) last saw the deceased alive on <i>6/17</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (let me) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>R.T. Benack MD</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.T. Benack MD</i> | | 22e. ADDRESS <i>4115 Colie Dr. Wheaton, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>6/18/86</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Gdn.; Falls Church; Fairfax; Va.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> | | 25. DATE REC'D. BY REGISTRAR <i>JUN 20 1986</i> 26. REGISTRAR'S SIGNATURE <i>Julia Benson-Radner</i> | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | |

75

3
00709514

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 17736
REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. DATE ESTIMATED | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS) | |
| Adrienne Louise Kaplan | | Female | | White | | 1 15 60 | | 26 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | United States | | WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | 5516 Besley Court, #T-7 | | None | | None | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5516 Besley Court, #T-7 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Irwin Kaplan | | Harriet Feder | | No | | 212-52-8545 | | Mr. & Mrs. Irwin Kaplan, Parents, 12812 Middlevale Lane, Silver Spring, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| Cardio Respiratory Arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| Seizure Disorder | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| | | | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | |
| John Tauber | | Deputy Medical Examiner | | 6-13-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | |
| John Tauber | | 3218 Wisconsin Ave | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | June 16, 1986 | | Metropolitan Crematory | | Alexandria | | Virginia | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Pumphrey Funeral Homes, | | JUN 16 1986 | | June 16, 1986 | | | | | |
| 7557 Wisconsin Ave., Bethesda, MD. 20814 | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE MUST BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

118010

UNITED STATES AIR FORCE

WRIGHT PATTENSON AIR FORCE BASE

2000

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100. [Illegible text]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Panagiota</u> FIRST <u>...</u> MIDDLE <u>...</u> LAST <u>Karolis</u> | | | 2a. DATE OF DEATH
MONTH <u>06</u> DAY <u>06</u> YEAR <u>86</u> | | | 2b. HOUR
<u>7:15</u> M | | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Can.</u> | | 5. DATE OF BIRTH
MONTH <u>10</u> DAY <u>25</u> YEAR <u>06</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>79</u> YRS. | | 7. IF UNDER 1 YEAR
MONTHS <u>...</u> DAYS <u>...</u> | | 8. IF UNDER 24 HRS
HOURS <u>...</u> MIN. <u>...</u> | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) <u>Greece</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring, Md</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sylvan Manor Health Care Center</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<u>MD</u> | | | | 13b. CITY OR TOWN
<u>Montgomery Silver Spring</u> | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<u>10005 Sidney Rd. 20901</u> | | | |
| 14. FATHER'S NAME
FIRST <u>Petros</u> MIDDLE <u>...</u> LAST <u>Petropoulos</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Helen</u> MIDDLE <u>...</u> LAST <u>Papatheodoroo</u> | | | | 16. ADDRESS
<u>Sophia Shiaris Sister Same as 13</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | | | 16b. SOCIAL SECURITY NO.
<u>N/A</u> | | 17. INFORMANT
<u>Sophia Shiaris Sister Same as 13</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY FAILURE-ACUTE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ADVANCED GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>...</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 YRS.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>SENILE DEMENTIA ; CONVULSIVE DISORDER</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>...</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>...</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>N/A</u> <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u>N.A.</u> | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>JAN 15</u> , 19 <u>1980</u> , to <u>JUNE 6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 23</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John B. Nason, MD</u> | | | | | | DEGREE
<u>...</u> | | | 22c. DATE SIGNED
<u>6-6-86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JOHN B. NASON, MD</u> | | | | | | 22e. ADDRESS
<u>800 BRUSHING DR. SILVER SPRING, MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>Burial</u> | | | 23b. DATE
<u>June 9, 1986</u> | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Rockville Montgomery Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME <u>Francis J. Collins, Jr.</u>
<u>500 University Blvd., W. Silver Spring, Md.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>JUN 11 1986</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>...</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000
7-20-00

From: [illegible]
To: [illegible]

Subject: [illegible]

[illegible]
[illegible]
[illegible]

70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 3 8

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Isadore I. Katz | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 30-86 | | 2b. HOUR
1: P. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 30 09 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
77 | | IF UNDER 24 HRS.
HOURS MIN.
77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dry Cleaning | | 12b. KIND OF BUSINESS OR INDUSTRY
Wholesale Owner | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12c. KIND OF BUSINESS OR INDUSTRY
Wholesale Owner | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Katz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jenny Jaffee | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16a. SOCIAL SECURITY NO.
578-10-9000 | | 17. INFORMANT
Janet L. Eckhaus (Same as # 13) | | ADDRESS
15024 Butterchurn Lane 20904 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) anoxic encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
(b) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(c) myocardial infarction
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: myocardial infarction, chronic renal failure, diabetes mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days
7 days | | | |
| 19a. DATE OF OPERATION
June 23, 1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
myocardial infarction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 23, 1986 to June 30, 1986 , that (I) (we) lost
saw the deceased alive on June 29, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. If (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Mark S. Rosen MD | | 22c. DATE SIGNED
6/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark S. Rosen | | 22e. ADDRESS
3941 Ferrara Drive, Silver Spring, MD | | 22f. DATE SIGNED
6/30/86 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
7/1/1986 | | 23c. NAME OF CEMETERY OR CREMATOR
Ohey Shalom Talmud Torah Congregation | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D. C. | | 23e. DATE REC'D. BY REGISTRAR
7/1/86 | | 23f. REGISTRAR'S SIGNATURE
[Signature] | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

100-1000



RECEIVED
JUN 10 1964
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

00-11008

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17739

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Max Katz | | | 2a. DATE OF DEATH
MONTH 6 DAY 24 YEAR 86 | | | 2b. HOUR 2:45 M | | | | | |
| 3. SEX
male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 3 DAY 17 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 6. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 6. IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TAILOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13e. STREET ADDRESS / ZIP CODE
1111 UNIVERSITY BOULEVARD, WEST 20902 | | | | | |
| 14. FATHER'S NAME
FIRST SAMUEL MIDDLE KATZ LAST LEAH | | | | 15. MOTHER'S MAIDEN NAME
FIRST LEAH MIDDLE KREISEL LAST KREISEL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
578-42-1178 | | 17. INFORMANT SARA KATZ, SILVER SPRING, MARYLAND | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left cerebral aneurysm Ent. hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic vascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Arteriosclerotic vascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-23-86 to 6-23-86 , that (I) last saw the deceased alive on 6-23-86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. David Geiger M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6-24-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID GEIGER, M.D. | | 22e. ADDRESS
8830 CAMDEN RD. SILVER SPRING, MD 20910 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
6/26/1986 | | 23c. NAME OF CEMETERY OR CONGREGATION
BNAT ISRAEL CONGREGATION | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PRINCE GEORGE'S MARYLAND | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | | | | | | | | |
| 25. DATE REC'D BY REGISTRAR
JUN 26 1986 | | | | | | | | | | | |
| 26. REGISTRAR'S SIGNATURE
Julia Henderson-Rodriguez | | | | | | | | | | | |

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "ORIGINAL" and "OFFICE" are visible at the top.]

00-10343

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|---------------------|--|---|---|--|---|--|--|--|---|--|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
WAH | | MIDDLE
DUN | | LAST
KAW | | 2b. DATE KNOWN OF DEATH
ESTIMATED
June 19 1988 | | 2c. DATE OF DEATH
MONTH DAY YEAR
June 19 1988 | | 2d. HOUR
1201 AM | |
| 3. SEX
M | 4. RACE
Oriental | 5. DATE OF BIRTH
MONTH DAY YEAR
April 28 1959 | 6. AGE (IN YEARS)
LAST BIRTHDAY
29 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2e. DATE PRONOUNCED DEAD
June 19 1988 | | 2f. HOUR
1202 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Sil. Spg. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Chef | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sil. Spg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4716 Iris Pl. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Song Shun Kaw | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gam Kee Lee | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT (wife)
Mae Ha-Wong Kaw | | 12 Yale Place
Glencove, New York | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Bronchial Asthma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>Chronic Bronchial Asthma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>None</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>John S. Rogers</u> | | TITLE (SPECIFY)
M.D. <u>Dep.</u> | | MEDICAL EXAMINER | | DATE SIGNED
June 19 1988 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, DME | | ADDRESS
1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-25-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Cypress Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn New York | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | | | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1891-92

20% COTTON LIME

MADE IN U.S.A.

00-09814

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1- FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17741

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Chester H Keller | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 15 86 | | 2b. HOUR
MIN.
8:05 A |
| 3. SEX
Male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
4 25 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REALTOR (RET) | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE |
| 13a. STATE
MD | | | 13b. COUNTY
MONT. | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GILBERT N. KELLER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CATHERINE ACKER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-05-5239 | | 17. INFORMANT
ADDRESS
GERALDINE C. KELLER - 14708 HIRSH RD S.S MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
60 mins
Hours
Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
COPD. Cor Pulmonale. Heart Failure. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 14, 1986 to June 15, 1986 , that (I) (we) lost
saw the deceased alive on June 14, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
HUGO G GRAZIANI | | DEGREE
MD | | 22c. DATE SIGNED
6-15-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUGO G GRAZIANI MD | | 22e. ADDRESS
217 PERSHING Drive SILVER SPRING MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JUNE 18, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY BRIGHTWOOD | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home, J.G. Walters | | ADDRESS
251 Carroll Creek Dr | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

JOHN H. KELLER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8617742 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ADELE | | MIDDLE KENT | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YEAR | |
| Female | | white | | March 8, 1898 | | 88 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Austria | | USA | | | | Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | Shady Grove Adventist Hosp | | Owner (Retired) | | Art Boutique | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 299 Hurley Avenue 20850 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| FIRST (unknown) | | LAST (unknown) | | NO | | 578-46-7720 | | 20815 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) | | | | | | | | | |
| (c) | | | | | | | | | |
| Cerebro-vascular accident | | | | | | | | hours | |
| Hypertension | | | | | | | | years | |
| Arteriosclerosis | | | | | | | | " | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | | | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | |
| | | P.M. 19 | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | June 19 85 | | to | | June 19 85 | | that (I) (the) last saw the deceased alive on | |
| | | | | | | | | above, (I) (did) (did not) view the body after death. | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| This is the medical examiner | | | | 6/23/85 | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | 22g. DATE SIGNED | | 22h. REGISTRAR'S SIGNATURE | | | |
| This is WARD | | 6116 Robinson Rd Bethesda 20817 | | JUL 03 1986 | | Julia Dindon-Rodriguez | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | 6-30-1986 | | Lee's Crematory | | Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE SIGNED | | 24d. REGISTRAR'S SIGNATURE | | | |
| DAN ZANSKY-GOLDBERG MEM. CHPLS. | | 1170 Rockville Pike; Rockville, Md. 20852 | | JUL 03 1986 | | Julia Dindon-Rodriguez | | | |

BP

11520

Apple white
Kent

Apple white
Kent

Apple white
Kent

00-10844

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617743
REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE ON PRINT)
FIRST MIDDLE LAST
<i>Nicholas Keslosky</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>6/24/86</i> | | | 2b. HOUR
<i>6:00 p.m.</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 19 1904</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>81</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>10423 Hebard Street</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Cabinet Maker</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Kensington</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Nestody Kiesielousky</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Cicura</i> | | | |

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WW II</i> | | 17. INFORMANT
<i>Natalie P. Keslosky</i> | | ADDRESS
<i>Wife Same as 13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> | | DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>Chronic Obstructive Pulmonary Emphysema</i> | | DUE TO, OR AS A CONSEQUENCE OF:
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 mos</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | 10 years | | | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/5/83</i> 19____, to <i>6/24/86</i> 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Robert C. Macon</i> | | | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>6/25/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE ON PRINT)
<i>Robert C. Macon</i> | | | | 22e. ADDRESS
<i>M.D. 809 Viers Mill Rd. Rockville, Md 20851</i> | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>June 27, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Silver Spring Montgomery Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Collins, Jr.</i> | | | | 25. DATE REC'D BY REGISTRAR
<i>JUN 30 1986</i> | | | |
| 500 University Blvd. Silver Spring, Md. | | | | 25b. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

BP

00-09695

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the physician's name is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, there was any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 7 4 4
REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| | | FIRST MIDDLE LAST
Mary Ward KING | | MONTH DAY YEAR
June 2, 1986 | | 3:45 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 28, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Music Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles W. Ward | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Norine King | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-42-3831 | | | |
| | | | | 17. INFORMANT
ADDRESS
Ellsworth M. King, Item 13 | | | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION - CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(b) ISCHEMIC CARDIOMYOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c) MYOCARDIAL INFARCTION | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
4 YEARS
4 YEARS | | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS | | | | | | | |
| | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 13, 1982, to JUNE 2, 1986, that (I) (we) lost saw the deceased alive on JUNE 1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | 22b. SIGNATURE
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| | | 22c. DATE SIGNED
June 2, 1986 | | 22d. PHYSICIAN'S NAME (IF EXAMINER)
DR. GREGORY KOP | | | | 22e. ADDRESS
13-15 E. Deer Park Dr., Gaithersburg, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 5, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Wesley Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodfield, Montgomery, Md. | | | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, P.A., Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
JULIA DAVISON-RODERS | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617745
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|--|--------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
REBECCA KLEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/28/86 | | 2b. HOUR
6:10A | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/16/00 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Handicapped | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Klein | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Arma Middleman | | 16. SOCIAL SECURITY NO.
219-54-9368 | | | |
| 17. INFORMANT
Martin Kamerow | | 18. ADDRESS
Bethesda, Md 20852 | | | | 19. ADDRESS
7420 Westlake Terrace | |

| | | | |
|--|--|--|--|
| 10. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MIN | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) RESTRICTIVE LUNG DISEASE | | 5 YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) KYPHOSCOLIOSIS | | 20 YEARS | |

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PARANOID DELUSIONAL STATE**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8/22 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)
8/22 85 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6/28 86 | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/28 86 to 6/28 86 , that (we) last saw the deceased alive on 6/28 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Steven Lipson | | | | DEGREE | | 22c. DATE SIGNED
6/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | | | 22e. ADDRESS
6121 MONTROSE RD, ROCKVILLE | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 29, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Mem. Chaps., Rockville, Md 20851 | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 01 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | |

00-41503
2

RECEIVED
KERN
JUL 10 1962
4-52 30 G100



RECEIVED
KERN
JUL 10 1962
4-52 30 G100

RECEIVED
KERN
JUL 10 1962
4-52 30 G100

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00-09844

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | 8 6 1 7 / 4 6 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Lillian M Kloppel | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
6 14 1986 7:15 AM | | | | | |
| 3. SEX
F | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
July 12 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE
Md. | | 13b. COUNTY
BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
201 Woodlawn Rd. 21210 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edward Kloppel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. Berger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
22044 4077 | | 17. INFORMANT ADDRESS
800 Southerly Rd. Ms. Emma Mulbach Towson, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED OFFICE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 23</u> 19 <u>86</u> to <u>June 14</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>June 9</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold F. McCann M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6-14-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | | | 22e. ADDRESS
4362-26th St. N Arlington, Va 22207 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
6-14-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

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100-00

100-00

100-00



0-09896

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with the death certificate.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

17747

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Edward Knisley | | | 6 17 86 | | | 12:10 M | | | |
| 3. SEX
M | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
6 10 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
68 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cab Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Cab Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Ann Arundel Laurel | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Box 296 Brockbridge Rd 20707 | | | | |
| 14. FATHER'S NAME: FIRST MIDDLE LAST
Charles Edward Knisley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Jane Howell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)
Yes 1944-1946 | | | 16b. SOCIAL SECURITY NO.
212-14-5621 | | 17. INFORMANT ADDRESS
Marion Knisley Box 296 Brockbridge Rd Laurel Md 20707 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic prostate Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 wks
1 year | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)
6/15/86 to 6/17/86 | | | |
| 22a. I certify that at the hospital attended the deceased from 6/16/86 to 6/17/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | |
| 22b. SIGNATURE
Thomas P. Bensinger | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/17/86 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas P. Bensinger | | | 22e. ADDRESS
7525 Greenway Cir Drive Greenbelt MD 20770 | | | | | | |
| 23b. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23c. DATE
6-20-86 | | 23d. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. | | 23e. LOCATION CITY OR TOWN COUNTY STATE
Crownsville AA MD | | |
| 24. FUNERAL DIRECTOR
Fleish Funeral Home Inc.
7601 Sandy Spring Rd. Laurel Md 20646 | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JUN 19 1986 | | | | | | |

00-08804

DIVISION OF VITAL RECORDS, 205 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

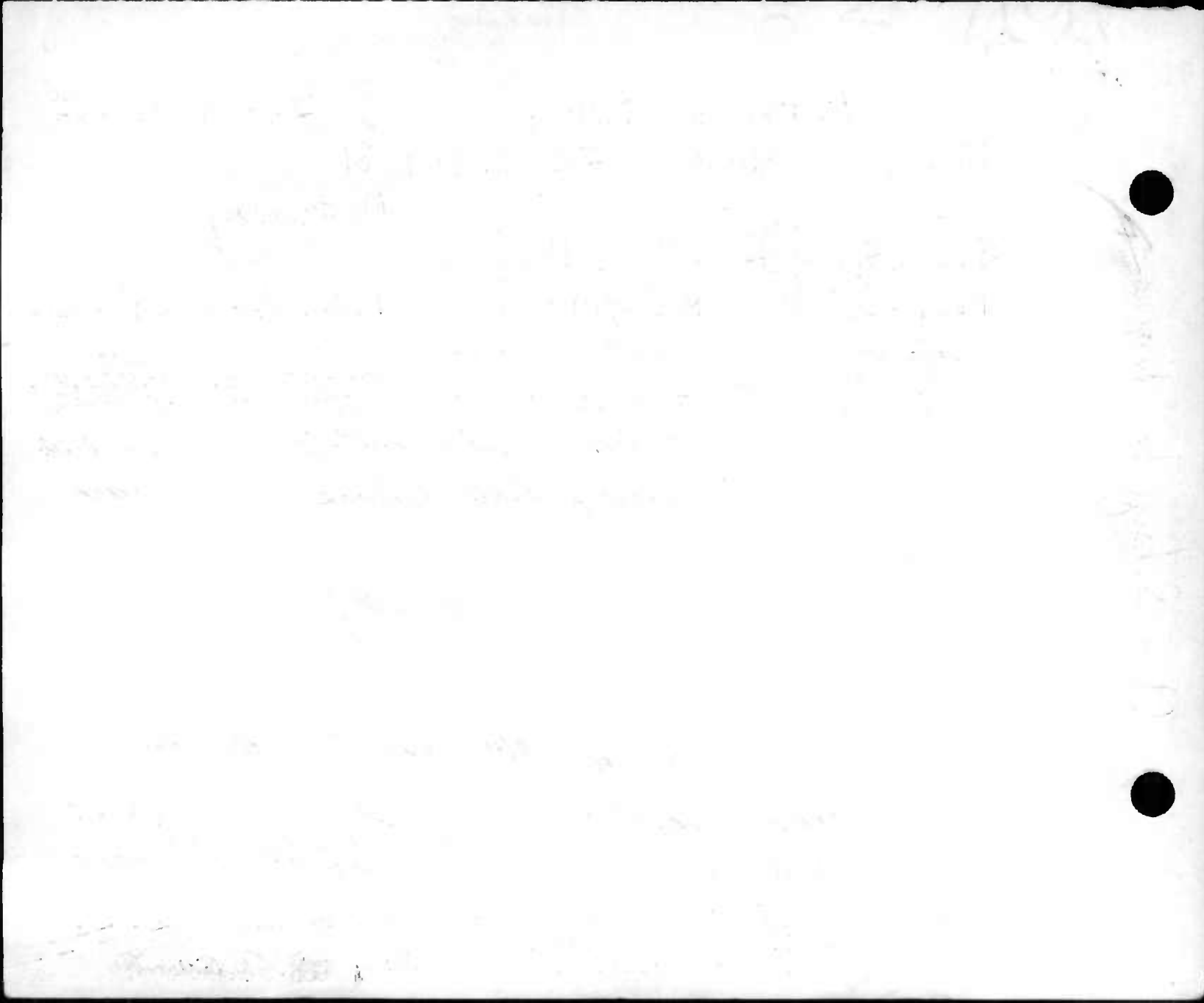
DHMM - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17748

REG. NO.

| | | | | |
|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RATHERINA KNOOP | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 4 1986 | | 2b. HOUR 2 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 26 1984 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE MARYLAND 13c. COUNTY Mont. 13d. CITY OR TOWN Kensington | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13f. STREET ADDRESS & ZIP CODE
10920 Conn. Avenue 20845 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernhard Renner | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Elise Fehse | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
N/A | 16b. SOCIAL SECURITY NO.
579 54 9242 | 17. INFORMANT'S NAME & ADDRESS
Rosalie Santilhano (Daughter) 20853 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest - atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/4 , 19 86 , to 6/4 , 19 86 , that (I) (we) lost
saw the deceased alive on 6/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (not) see the body after death. | | | | |
| 22b. SIGNATURE
B.A. ROSENBAUM, D.D. | DEGREE
ATTENDING PHYSICIAN | 22c. DATE SIGNED
6/4/86 | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.A. ROSENBAUM | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/6/86 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Mont. Md. | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | 11800 New Hamp Ave.
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 9 1986 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rose | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 86 17749 | |
|--|--|--|---|---|--|--|---|---|------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Marie Myrtle Kruger</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>6-27-86</i> | | | 2b. HOUR
<i>10:45</i> M | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>12 26 1906</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>79</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Buyer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Department Store</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>Maryland P.G.</i> | | | 13b. CITY OR TOWN
<i>Hyattsville</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<i>3907 Longfellow Street 20781</i> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>John R. Clark</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Fannie Ridgel</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN | | | | | |
| 16b. SOCIAL SECURITY NO.
<i>579-22-1513</i> | | | 17. INFORMANT ADDRESS
<i>Joan Facchina (Daughter) Hyattsville, Md. 20781</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>unauter</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>oropharyngeal carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>6/16 1986</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>6/16</i> to <i>6/27</i> , 19 <i>86</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE
<i>DJ HAUDEK</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>6/27/86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>DJ HAUDEK</i> | | | 22e. ADDRESS
<i>Clinton, Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>07/01/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln Cemetery</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Brentwood P.G. Maryland</i> | | | |
| 24. FUNERAL HOME OR OTHER INSTITUTION
<i>Francis Gosch's Sons Funeral Home, P.A.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JUL 7 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |
| 4739 Baltimore Avenue Hyattsville, Md. 20781 | | | | | | | | | | | |

BP

1121

WILKINSON

100% COTTON FIBER

MADE IN U.S.A.

0-10379

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17750

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SUMIE KURIHARA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 23, 1986 | | | 2b. HOUR
1:00 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
JAPANESE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 2, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
HAWAII | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7607 GERANIUM STREET | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7607 GERANIUM STREET 20817 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ENJIRO OKI | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TOKI FUJITANI | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
575-24-1169 | | 17. INFORMANT
ADDRESS
JAMES Y. KURIHARI, HUSBAND, SAME AS ITEM #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Colon Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February , 19 85 , to June , 19 86 that (I) (we) lost
saw the deceased alive on June 18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thomas Sacks | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas Sacks | | | | 22e. ADDRESS
2201 L St. N.W. Wash. D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
6/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
ADDRESS
1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-09142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17751

| | | | | | | | | |
|--|---------------------------|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Molly K. Kwauk | | | 7b. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 5 86 | | | 7d. HOUR 400 PM | | |
| 3. SEX
Female | 4. RACE
Chinese | 5. DATE OF BIRTH
MONTH DAY YEAR 2 26 37 | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 6 5 86 | 7d. HOUR 5 12 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
China | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Craftsperson | | 12b. KIND OF BUSINESS OR INDUSTRY
Crafts | |
| 13a. STATE
MD | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
10424 Masters Terrace/20854 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mei Son Kwauk | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Y. Ma | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
403-68-8160 | | 17. INFORMANT ADDRESS
James H. Ma, Same address as #13. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
John Tauber | | M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 6-5-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | ADDRESS
8218 | | Bethesda | | 4135 Con St NW | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, VA | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson | | |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | | | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

Kwan

A.

Kelly

Chinese

China

China

Griffith

Griffith

Griffith

Griffith

1045 Masters Terrace \50524

x

Thomas

Montgomery

MD

No

L.

Griffith

Kwan

Don

Met

James E. M., same address as 15.

403-88-8100

No

Alexandria, VA

Met. Comfort Observatory

6/10/86

Griffith

Joseph Gwiler's Home, Inc.

2150 Macomah Ave., N.W., Washington, D.C. 20016

00-10495

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 7 5 2

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST Agnes MIDDLE B. LAST Lacy | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6/22/86 248 M | | | |
| 3. SEX female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1/25/02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE --- | | | | 13b. COUNTY --- | | 13c. CITY OR TOWN Washington, DC | |
| 14. FATHER'S NAME FIRST Samuel MIDDLE G. LAST Baptist | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE --- LAST Chandler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578-62-1946 | | 17. INFORMANT ADDRESS Alton G. Lacy, Same address as #13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL INFARCTS
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) --- | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from MARCH 19 84 to 22 JUNE 19 86, that (we) last saw the deceased alive on 22 JUNE 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Walter E. Gooch MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 23 JUNE 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD | | | | 22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Scottsburg, VA | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR JUN 25 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

RECEIVED

NOV 1964

11-11-64

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

[illegible]

RE: [illegible]

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00-11518

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, 2, and 3, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or how, it should be filed with the medical examiner, not with the funeral director.

Cleared by medical examiner 6/30/86

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 86 17753 | |
|--|--|--|--|--|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | Edith C. Lakey | | June 30, 1986 | | 4:04 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | | |
| Female | | White | | Feb. 7, 1902 | | 84 YRS | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | | |
| Unknown | | Unknown | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Olney | | Montgomery General Hospital | | Homemaker | | Home | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| MD | | Montgomery | | Olney | | | | 18201 Marden Lane 20832 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Unknown | | Unknown | | No | | 312-64-5851 | | Sil. Spg., MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Cardiovascular collapse | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | (b) | | Ruptured aortic aneurysm | | | | 6/30/86 | | | |
| | | (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30 1986, to 6/30 1986, and that (I) (we) lost saw the deceased alive on 6/30 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| | | GEOFFREY M. WILNER | | M.D. | | 6/30/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | | | |
| GEOFFREY M. WILNER | | MONTGOMERY GENERAL HOSP., OLNEY, MD. | | JUL 7 1986 | | Julia Davidson-Randall | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 7/3/86 | | Quantico Nat'l. Cem. | | Quantico, VA | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | | | | |
| Gowlers Funeral Home | | 25130 WI Ave NW 20016 | | JUL 7 1986 | | Julia Davidson-Randall | | | | | |



Unknown

No

115-64-1001

Nathaniel M. Harrison 12015

Unknown

12015 Harrison James

Montgomery Cliney

x

Homer

Homer

Nov. 11, 1902

84

James M. Harrison 12015

James M. Harrison 12015

12015

12015

00-11516

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 7 7 5 4

| | | | | | | | | | |
|---|--|---|---|---|----------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Hetty Green Lawrence | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 29, 1986 | | 2b. HOUR
1:22 pm | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 3, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15101 Interlachen Drive #622 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Vernon Green | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Columbia Williams | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW I | | | | 16b. SOCIAL SECURITY NO.
577-24-7222 | | 17. INFORMANT
ADDRESS
Patricia L. Foley Upper Marlboro, Md. 20772 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(b) Calcific aortic stenosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days

years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Coronary arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 19 86 , to 6-29 19 86 , that (I) (we) last saw the deceased alive on 6-29-86 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Alberto Rotsztain</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
7/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alberto Rotsztain, M.D. | | | | 22e. ADDRESS
Suite 204 10401 Old Georgetown Rd. Bethesda, Md. 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
July 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey, Funeral Homes, P.A. 7557 Wisconsin Ave. Bethesda, Md. 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

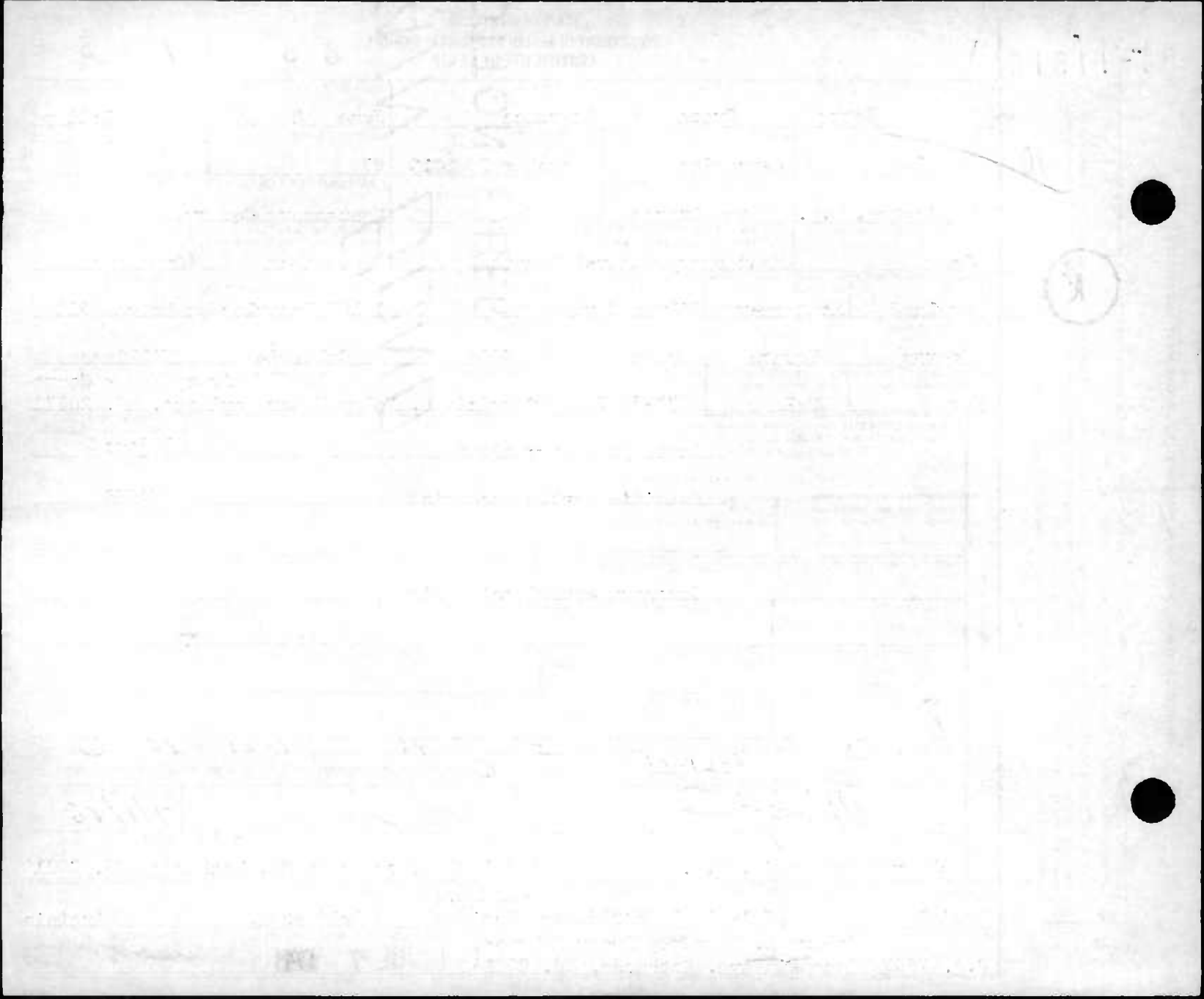
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 7 7 5 5

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM RAYMOND LEFEVRE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 7 1986 | | | 2b. HOUR
10:57 P
M | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 30 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2927 MOZART DRIVE 20904 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EVERETT RAYMOND LEFEVRE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDITH VIOLET REPP | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1958-1967 | | 16c. 486-34-9995 | | 17. INFORMANT
ADDRESS
JANICE L. FLUG, 2927 MOZART DRIVE, SILVER SPRING, MD 20904 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF THE COLON
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 8 , 19 86 , to JUNE 7 , 19 86 , that (I) (we) lost
saw the deceased alive on JUNE 7 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>J. M. Guinee</i> MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9 JUN 86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. M. GUINEE, LT. MC, USNR | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
June 12, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION
CITY OR TOWN COUNTY
Arlington Virginia | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

BP

RECEIVED
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17756

| | | | | | |
|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. DATE OF BIRTH | | 3. AGE (IN YEARS) | |
| Bertha Pearl Lener | | Dec. 9, 1905 | | 80 YRS. | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | |
| White | | Dec. 9, 1905 | | 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| PENNA | | U.S.A | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | 100 Plymouth Street | | NONE | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Montgomery | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| WILLIAM J. LENER | | LILIA BALDWIN | | 188-46-1478 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 188-46-1478 | | JAMES ALLAMON, 710 ROEDER RD. SS. MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Acute myocardial disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) chronic myocardial disease. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | P.M. 19 | | None | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John S. Rogers, M.D. | | Deputy | | 6/26/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| John S. Rogers, M.D. | | 1919 Seminary Road Silver Spring, Montgomery County, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | JUNE 27, 1986 | | B/N. CREMATORY | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Takoma Funeral Home J. G. Walker | | 254 Carroll St NW DC | | JUN 30 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | John S. Rogers, M.D. | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO THE CHIEF MEDICAL EXAMINER WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



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U.S.A.

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0-10831

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANX DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17758

| | | | | | | | |
|--|---|---|---|---|------------------|---|----------|
| 1. STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | Eugene Leo Lentz | | 6 25 86 | | 11 35 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | White | May 22, 1923 | 63 YRS. | | | 6 25 86 | 11 35 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Iowa | United States | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | 864 College Parkway A-101 | | | Computer Analyst | | Medical Library | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Maryland | Montgomery | Rockville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 864 College Parkway A-101 Zip: 20850 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | | |
| Leo Lentz | | May Cook | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) ADDRESS | | | |
| Yes | | WWII 481-16-4461 | | Rosemary E. Lentz Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of the lung.</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | |
| (b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | MEDICAL EXAMINER | |
| John Tauber | | Deputy | | June 25, 1986 | | Bethesda Md. | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| John Tauber | | 8218 Wisconsin Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Cremation | | June 26, 1986 | | Metropolitan Crematory | | Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey | | JUN 30 1986 | | John Tauber | | | |
| 300 West Montgomery Avenue Rockville, Maryland | | | | | | | |

07/84
25M

BP
DHMH - 17
(VR AT5 ME (5))

RECEIVED

APR 11 1961

202

OFFICE

1/1

1/1

1/1



100-1-0

0-11103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

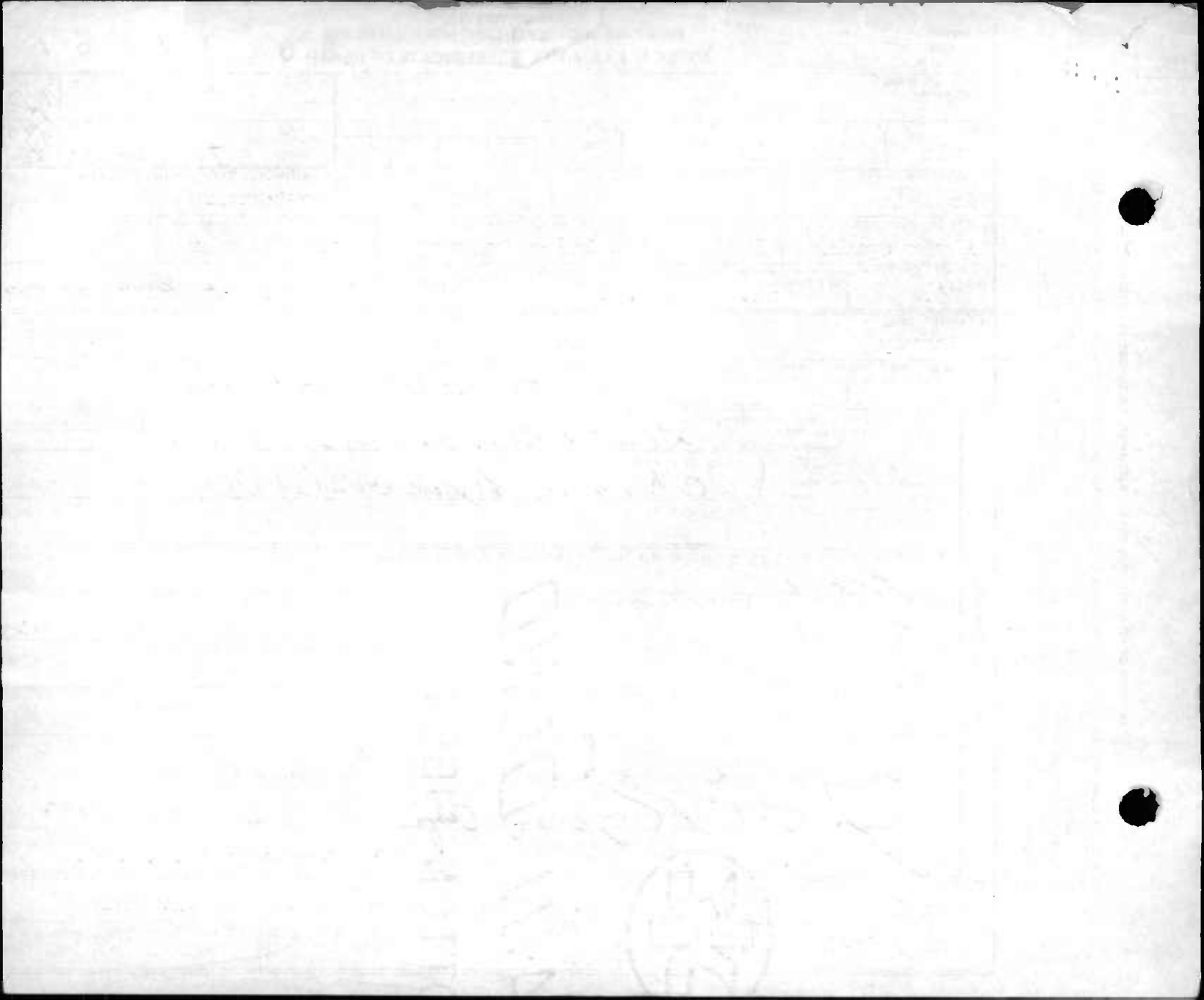
DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17757

| | | | | | | | |
|--|---|---|--|---|--------------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 6 28 86 | | 9:30 | |
| Homer | | LeSueur | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | MONTH DAY YEAR |
| Male | White | 12 10 96 | 89 | MONTHS DAYS | HOURS MIN. | June 28 1986 | 9:30 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | USA | | | | Montgomery | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | 10612 Sweet Briar Parkway | | | Dairy Farmer | | Retired | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Md. | Mont. | S.S. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 10612 Sweet Briar Parkway | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | |
| Harvey | | | Mae | | Hall | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Same as 13E | | |
| N/A | | | 223 48 8037 | | Virginia Smith (Daughter) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | |
| (b) <u>Chronic Myocardial Dis.</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| None | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | |
| [Signature] | | M.D. [Signature] | | | | 6/28/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| Dr. John S. Rogers | | 1919 Seminary Rd. S.S. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | 6/30/86 | Mountain View Cemetery | | Bristol, Virginia | | | |
| 24. FUNERAL DIRECTOR | | 11800 New Hamp. Ave. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hines/Rinaldi | | Silver Spring, Md. | | JUL 1 1986 | | | |



00-10173

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17759

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------------------|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEAN BOTTS LEWIS | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
June 17 1986 | | | 2b. HOUR
12:30 P.M. | | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC 7 1933 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
52 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
June 17 1986 | 7d. HOUR
1:30 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Post Office | |
| 13a. STATE
D.C. | | 13b. COUNTY
N/A | 13c. CITY OR TOWN
Wash. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2300 Gard Hope Rd E. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HORACE BOTTS, SR. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GLADYS COOMBS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
577-42-0363 | | 17. INFORMANT
13728 INWOOD LN. STANLEY BOTTS - SILVER SPRING, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suicide by car dist. dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
Dep. | | MEDICAL EXAMINER | | DATE SIGNED
June 17 1986 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
JOHN S. ROGERS | | ADDRESS
1919 SEMINARY RD., SIL. SPRING, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE
6/20/86 | 23c. NAME OF CEMETERY OR CREMATORY
LINCOLN MEM. CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND, P.G., MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
H.S. WASHINGTON & SONS | | | ADDRESS
4925 BURROUGHS AVE, N.E. | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RELAY PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Dec 1952



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00-11884

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17760

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALEXANDER MORSELL LOKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 30 1986 | | 2b. HOUR
1:53 P.M. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 15 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE | | 13b. COUNTY | 13c. CITY OR TOWN
WASHINGTON, D.C. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4000 CATHEDRAL AVE., NW 20016 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE PEABODY LOKER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH MORSELL LAMDEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1921-1951 | 17. INFORMANT
ADDRESS
DONZEL LOKER, 9327 WEATHERVANE PLACE, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PROSTATE CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 30</u> 19 <u>86</u> , to <u>JUNE 30</u> 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>JUNE 30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>J. H. Edmunds</i> | | DEGREE
MD | | 22c. DATE SIGNED
7 Jul 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. H. EDMUNDS, LCDR, MC, USN | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
7/7/86 | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | 25a. DATE REC'D. BY REGISTRAR
JUL 9 1986 | | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



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ADVERSE INFORMATION

JUL 8 1968

U.S. DEPARTMENT OF JUSTICE

00-08769

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17761

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|----------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Margaret Levada LONG | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 1 86 | | 2b. HOUR
10:35 PM | | |
| 3. SEX
female | | 4. RACE
caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar 29, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Eva Morgan | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | |
| 16b. SOCIAL SECURITY NO.
193 16 3306 | | 17. INFORMANT ADDRESS
Rita Joan Long, daughter, see #13 | | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardio Pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute cerebral vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Abdomen</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/29/86</u> , 19 <u>86</u> , to <u>6/1/86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6/1/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Ther. O. KMIANEY</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MIRY. O. KMIANEY | | 22e. ADDRESS
20428 Germantown Rd, Germantown, Md. 20874 | | | | | |

| | | | | | | | |
|---|--|---------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial/Transit | | 23b. DATE
June 4, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Blairsville Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Indiana County, Penna. | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, PA
NAME ADDRESS
7557 Wisconsin Av., Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 6 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

RECEIVED
JAN 10 1964

02507-0

| DATE | DESCRIPTION | AMOUNT |
|---------|-------------|--------|
| 1/10/64 | ... | ... |
| 1/11/64 | ... | ... |
| 1/12/64 | ... | ... |
| 1/13/64 | ... | ... |
| 1/14/64 | ... | ... |
| 1/15/64 | ... | ... |
| 1/16/64 | ... | ... |
| 1/17/64 | ... | ... |
| 1/18/64 | ... | ... |
| 1/19/64 | ... | ... |
| 1/20/64 | ... | ... |
| 1/21/64 | ... | ... |
| 1/22/64 | ... | ... |
| 1/23/64 | ... | ... |
| 1/24/64 | ... | ... |
| 1/25/64 | ... | ... |
| 1/26/64 | ... | ... |
| 1/27/64 | ... | ... |
| 1/28/64 | ... | ... |
| 1/29/64 | ... | ... |
| 1/30/64 | ... | ... |
| 1/31/64 | ... | ... |
| TOTAL | | ... |



2009 CCLIC

0-10962

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 8 6 1 7 7 6 2
 REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN F LUKETT | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 26 86 | | | 2b. HOUR 1:08 M | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3 27 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN | | 8b. CITIZEN OF WHAT COUNTRY? USA | | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY N.I.H. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Apt. 320 10000 Brunswick Avenue 20902 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vernon Fuller | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Handley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-03-9493 | | 17. INFORMANT Daughter ADDRESS Bethesda, Maryland
Marian L. Dawson 9919 Brixton Lane 20817 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 d | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Breast cancer with bone + marrow mets, Renal failure. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/25 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 6/25 1986 to 6/26 1986 that (b) (we) last saw the deceased alive on 6/25 1986 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Peter Sherer MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 6/26/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD | | | | | | 22e. ADDRESS 3947 Ferrara Dr. Wheaton MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE June 28, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 30 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

APR 10 1964

FROM

TO

SUBJECT

REMARKS

DATE

TIME

LOCATION

BY

FOR

REMARKS

DATE

TIME

LOCATION

BY

FOR

00-09261

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17763

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ronnie Lansdale LYLES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 10, 1986 | | 2b. HOUR
9:34 A. | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 28, 1949 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
37 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | 10. CITY OR TOWN OF DEATH
Rockville | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Porter | | 12b. KIND OF BUSINESS OR INDUSTRY
Motel | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8300 McCullough La. Apt. 303 20877 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernard Eugene Lyles, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phoebe Anna Anderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-50-4626 | | 17. INFORMANT
Anna Mae Smith, Clarksburg, Md. 20871 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIOMYOPATHY**

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DOE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

PREBORNAL RENAL FAILURE, HYPERKALEMIA

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 31, 1986 to June 10, 1986 , that (I) (we) lost
saw the deceased alive on June 10, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael Anchors M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/10/1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Michael Anchors, M.D. | | | | 22e. ADDRESS
Main Street, Mt. Airy, Maryland | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 14, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Damascus, Montgomery, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Olin L. Molesworth, P.A., Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 12 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Michael Anchors</i> | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21a, any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Page 1

June 10, 1988

Memphis, Tennessee

27

March 26, 1989

Letter

Mail

Montgomery Co.

Marshall

Shady Grove Adventist Hosp.

Rockville

Letter

1000 Rockledge Dr. Apt. 303

Rockledge Dr. Apt. 303

Rockledge

Letter

Letter

Letter, 22

Letter, 22

1000 Rockledge Dr. Apt. 303

1000 Rockledge

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1000 Rockledge Dr. Apt. 303

1000 Rockledge Dr. Apt. 303

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1000 Rockledge Dr. Apt. 303

00-09364

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR | | 86 | | 17764 | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY B. MALINOWSKI | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 / 18 / 86 | | 2b. HOUR
10:30 A.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 13, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
13405 Oriental Court 20853 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Wojtczak | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Psybleski | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
389-68-5925 | | 17. INFORMANT ADDRESS
Marcella A. Davis same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest.
DUE TO, OR AS A CONSEQUENCE OF (b) Septic.
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 months. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension, Cardiac Arrhythmia, CHF, Anoxic Brain Damage | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A. | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/23/86 to 6/8/86 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ravi Passi | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/8/86. | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ravi Passi M.D. | | 22e. ADDRESS
14812 Physicians Ln. Suite 201, Rockville, Md. 20850 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Frances Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Superior, Wisconsin | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

00-1337



NOTICE OF PROCEEDINGS

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "notice" and "proceedings" are faintly visible.]

[Faint text at the bottom of the page, possibly a footer or additional notice details.]

2
00-10980

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17765

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GRETE PAULA MANNHEIM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 22, 1986 | | 2b. HOUR
11:30 PM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 14, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6908 NEVIS ROAD | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PHOTOGRAPHER | 12b. KIND OF BUSINESS OR INDUSTRY
PHOTOGRAPHY | |
| 13a. STATE
NEW YORK | | | 13b. COUNTY
NONE | 13c. CITY OR TOWN
BROOKLYN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
OSCAR SOLOMON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NANNA SCHLOSS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
128-26-7870 | | 17. INFORMANT (SON-IN-LAW) ADDRESS
ERIC BAIR, 6908 NEVIS ROAD, BETHESDA, MD. 20817 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) esophageal cancer

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) metastatic esophageal cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|--|---|---|--|
| 19a. DATE OF OPERATION
5/20/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
esophageal prosthesis placement | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1 P.M. 6 22 1986 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
June 13th | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
June 22 1986 | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 86 to June 22 1986 that (I) (we) last saw the deceased alive on June 22 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
David Fleischer | | DEGREE
MD | 22c. DATE SIGNED
6/23/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FLEISCHER, DAVID | | 22e. ADDRESS
Georgetown University Hospital | |

| | | | |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
6/23/86 | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-09532

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17766

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) **PHILIP NMI MARCUS** 2a. DATE OF DEATH MONTH DAY YEAR **June 11 1986** 2b. HOUR **6:46a** M.

3. SEX **Male** 4. RACE **Caucasian** 5. DATE OF BIRTH MONTH DAY YEAR **02 26 1907** 6. AGE (IN YEARS LAST BIRTHDAY) **79** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **New York** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **Montgomery** MD.

10. CITY OR TOWN OF DEATH **Wheaton** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **2020 Henderson Avenue** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Gov't. Attorney** 12b. KIND OF BUSINESS OR INDUSTRY **Dept. of Justice**

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE **Maryland** 13b. COUNTY **Montgomery** 13c. CITY OR TOWN **Wheaton** 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE **2020 Henderson Avenue 20902**

14. FATHER'S NAME FIRST MIDDLE LAST **Isaac** **Marcus** **Rose** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Louise** **Rosenthal**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **No** (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. **216-44-4033** 17. INFORMANT ADDRESS **Anna M. Marcus Wife Same As 13**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **pulmonary insufficiency** DUE TO, OR AS A CONSEQUENCE OF (b) **chronic lymphocytic leukemia** DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **19** P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **Sept 83** to **June 86**, that (I) (we) last saw the deceased alive on **June 4 1986**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE **Marcus S. Heltz** DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **June 11 1986**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **MARCUS D. HELTZ** 22e. ADDRESS **1525 Greenway LTR Bldg Greenbelt MD 20770**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Cremation** 23b. DATE **June 11 1986** 23c. NAME OF CEMETERY OR CREMATORY **Metropolitan Crematory** 23d. LOCATION CITY OR TOWN COUNTY STATE **Alexandria Virginia**

24. FUNERAL DIRECTOR NAME **Francis J. Collins, Jr.** ADDRESS **500 University Blvd. West Silver Spring, Md.** 25a. DATE REC'D. BY REGISTRAR **JUN 16 1986** 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

0-09899

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REC NO 17167

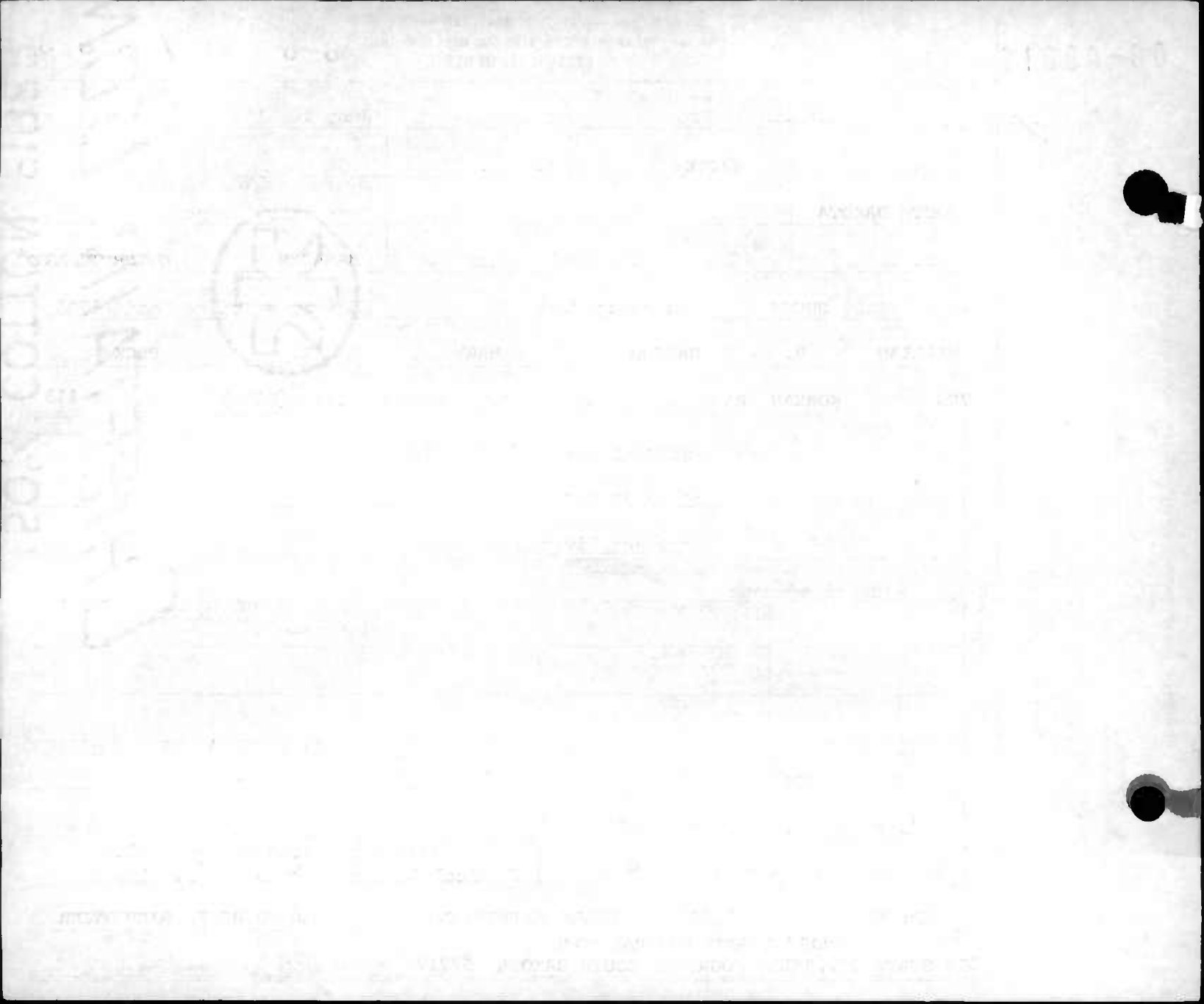
| | | | | | | |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Barbara Marie Marks | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 15, 1986 | | 2b. HOUR
4:30 a.m. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
May 12, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | |
| 7a. BIRTHPLACE
(COUNTRY) (STATE OR FOREIGN)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, The Clinical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Martin - Garrits | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie - Hall | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
168-20-3524 | | 17. INFORMANT
ADDRESS
Mr. Christopher J. Marks (son) Same as #13. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours
5 years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 27, 1986 to June 15, 1986 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 15, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | 22c. DATE SIGNED
June 15, 1986 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Greenberg | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20892 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Cremation | | 23b. DATE
June 17/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Co., Maryland | | 23e. DATE REC'D. BY REGISTRAR
JUN 19 1986 | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Maryland | | | | 25. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

72

Film G617 item 13b 7/14/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 7 6 8
REG. NO.

| | | | | | | | |
|--|--|--|---|---|------------------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Fred Matson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 16, 1986 | | 2b. HOUR
3:40 a.m. | | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 11, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH DAKOTA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, The Clinical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
ELECTRICAL ASSOC. | |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
Cumberland | | 13c. CITY OR TOWN
Mechanicsburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM R. MATSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY E. PECK | | 13e. STREET ADDRESS / ZIP CODE
5046 Erbs Bridge Road 17055 | | 99999 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
KOREAN ERA 504-22-3738 | | 17. INFORMANT
Mrs. Bonnie Matson (Wife) | | ADDRESS
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastro-intestinal bleeding
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) colon cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) Bone and liver metastases | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hrs
2 yrs
1 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
adrenal adenoma | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 29, 1986 , to June 16, 1986 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on June 16, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Diana P.E. Callender | | | | DEGREE
MD | | 22c. DATE SIGNED
6/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DIANA P.E. CALLENDER | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20892 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
BELLE FOURCHE CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BELLE FOURCHE, SOUTH DAKOTA | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FROST & SONS FUNERAL HOME
838 STATE ST., BELLE FOURCHE, SOUTH DAKOTA 57717 | | | | 25a. DATE REC'D. BY REGISTRAR
UN 18 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Romero</i> | |



00-09136

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17769

| | | | | | |
|---|---------|---|-------------------|--|---------------------|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1- DECEASED NAME (TYPE OR PRINT) | | 2c. DATE KNOWN OF DEATH | | 2d. HOUR | |
| Charles Eli Mattingly | | 6/6 1986 | | 6:30 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| Male | White | Sep. 2, 1924 | 61 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Kentucky | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | 12705 Feldon Street | | Dept. Director | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Maryland | | Montgomery | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| Raymond | | Mattingly | | 309-28-8633 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Jacqueline D. Mattingly Wife Same As 13 | | PART 1 DEATH WAS CAUSED BY: | | 3 years | |
| | | IMMEDIATE CAUSE (a) | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (b) carcinoma of the lung. | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| None | | None | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | None | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN | |
| | | | | COUNTY | |
| | | | | STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John S. Rogers, M.D. | | Deputy | | 6/6/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 1919 Seminary Road | |
| | | | | Silver Spring, Montgomery County, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | June 9, 1986 | | Arlington Nat'l. Cemetery | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis J. Collins, Jr. | | JUN 11 1986 | | John S. Rogers, M.D. | |
| 500 University Blvd. West Silver Spring, Maryland | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

10100-0

10100-0



10100-0

10100-0

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 7 7 0

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HUGH J McCall | | | 2a. DATE OF DEATH - MONTH DAY YEAR
6 20 86 | | 2b. HOUR
4:30 P.M. |
| 3. SEX
male | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
10 30 23 | 6. AGE - (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TIME OF WORKING LIFE)
Foreign Service Officer | 12b. KIND OF BUSINESS OR INDUSTRY
State Dept. | |
| 13a. STATE
MD | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. STREET ADDRESS / ZIP CODE
11501 Charlton Dr. 217-14-5711 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward E. McCall | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE (AUX)
Catherine Shanks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR DATES)
WW II 217-14-5711 | | 17. INFORMANT
ADDRESS
H. Dolores McCall Wife Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, right lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Small cell carcinoma, right lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>None</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1 month</u>
<u>6 months</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:20 P.M. 6 20 1986 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 72</u> to <u>June 20 19 86</u> , that (I) (we) lost
saw the deceased alive on <u>June 19 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (we did) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Seruch T. Kimble M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-20-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Seruch T. Kimble, M.D. | | 22e. ADDRESS
9801 Georgia Ave, Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
Jun. 21, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd., W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Gina Anderson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the State Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D.C. 20315

0-100-00



00-11109

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELIZA HAMMITT McCULLOUGH | | 2a. DATE KNOWN
OF DEATH June 17, 1986 | | 2b. HOUR
OF DEATH 8:45 PM | |
| 3. SEX Female | | 4. RACE Black | | 5. AGE (IN YEARS)
(LAST BIRTHDAY) 62 YRS. | |
| 6. DATE OF BIRTH Oct 26, 1926 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 64 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH S. L. Spc | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) Housewife | |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE DC 13b. COUNTY - 13c. CITY OR TOWN Wash | | 12b. KIND OF BUSINESS
OR INDUSTRY Domestic | | 12c. STREET ADDRESS 1665 North Portal Dr. N.W. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Melvin Hammitt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Rose Oliver | | 16. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-22-3167 | | 17. INFORMANT James McCollough (husband) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL
SIGNATURE John S. Rogers | | TITLE (SPECIFY) MD. | | DATE June 17, 1986 | |
| EXAMINER'S NAME
(TYPE OR PRINT) John S. Rogers, M.D. | | ADDRESS 1919 Seminary Road, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE 06/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park, Landover, P.G.Co. Maryland | |
| 24. FUNERAL DIRECTOR
NAME LATNEY'S FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR JUL 1 - 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | |
| 26. ADDRESS 3831 Ga. Ave. NW; Washington, D.C 20011 | | | | | |

DHMH - 17
(VR A15 ME (5))

2000 OCT 11 NO 1000

1000

1000



1000

00-09450

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17772
REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas J McCoy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 11 86 | | | 2b. HOUR
1:40 AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 21 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 6. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montg. County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Vice President | | 12b. KIND OF BUSINESS OR INDUSTRY
Mechanical Construction | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9606 Singleton Drive 20817 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas McCoy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Lyons | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 086-03-2979 | | 17. INFORMANT
ADDRESS
Mary R. McCoy wife same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/11/86 , to 6/11/86 , that (I) (we) last saw the deceased alive on 6/11/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
H-D. KHIANEY | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
June 11, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H-D. KHIANEY | | | | 22e. ADDRESS
20428 Germantown Rd, Croom, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | 24. FUNERAL DIRECTOR
ADDRESS
7557 Wisconsin Ave. Bethesda, Maryland 20814 | | 25a. DATE REC'D. BY REGISTRAR
JUN 13 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia... | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08-10841

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17773
REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANNIE | | | FIRST MIDDLE LAST McEvoy | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-21-86 | | | 2b. HOUR 7:00 M | | |
| 3. SEX Female | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH MONTH DAY YEAR 7-1-98 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse | | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 8700 Colesville Road 20910 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Rooney | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Walsh | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 097-20-2115 | | |
| 17. INFORMANT Son | | | ADDRESS Potomac, Maryland | | | 17. INFORMANT Patrick McEvoy | | | 17. INFORMANT 7905 Ivymount Terrace 20854 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Central Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Central arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerosis, Hemiparesis, Intercerebral plant disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 18, 1975 to JUNE 21, 1986 , that (I) (I) saw the deceased alive on JUNE 21, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Seamus T. Kimble M.D. | | | | | | DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 6-21-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SERUCH T. KIMBLE, M.D. | | | | | | 22e. ADDRESS 9801 Georgia Ave. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE June 24, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md. | | |
| 24. FUNERAL DIRECTOR Francis J. Collins, JR. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 30 1986 | | | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | 25b. REGISTRAR'S SIGNATURE James T. Kimble | | | | | |

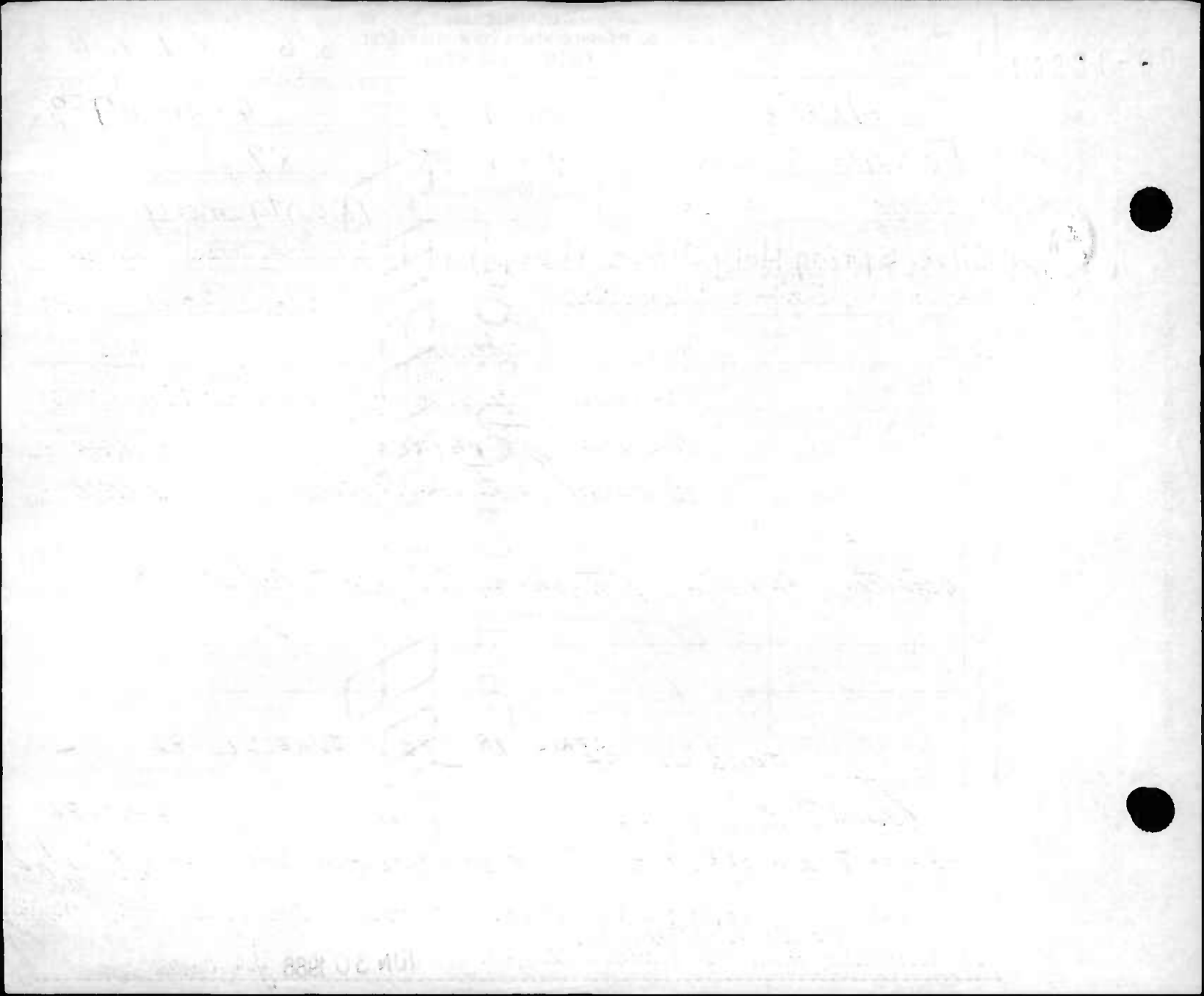
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.



00-12075

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

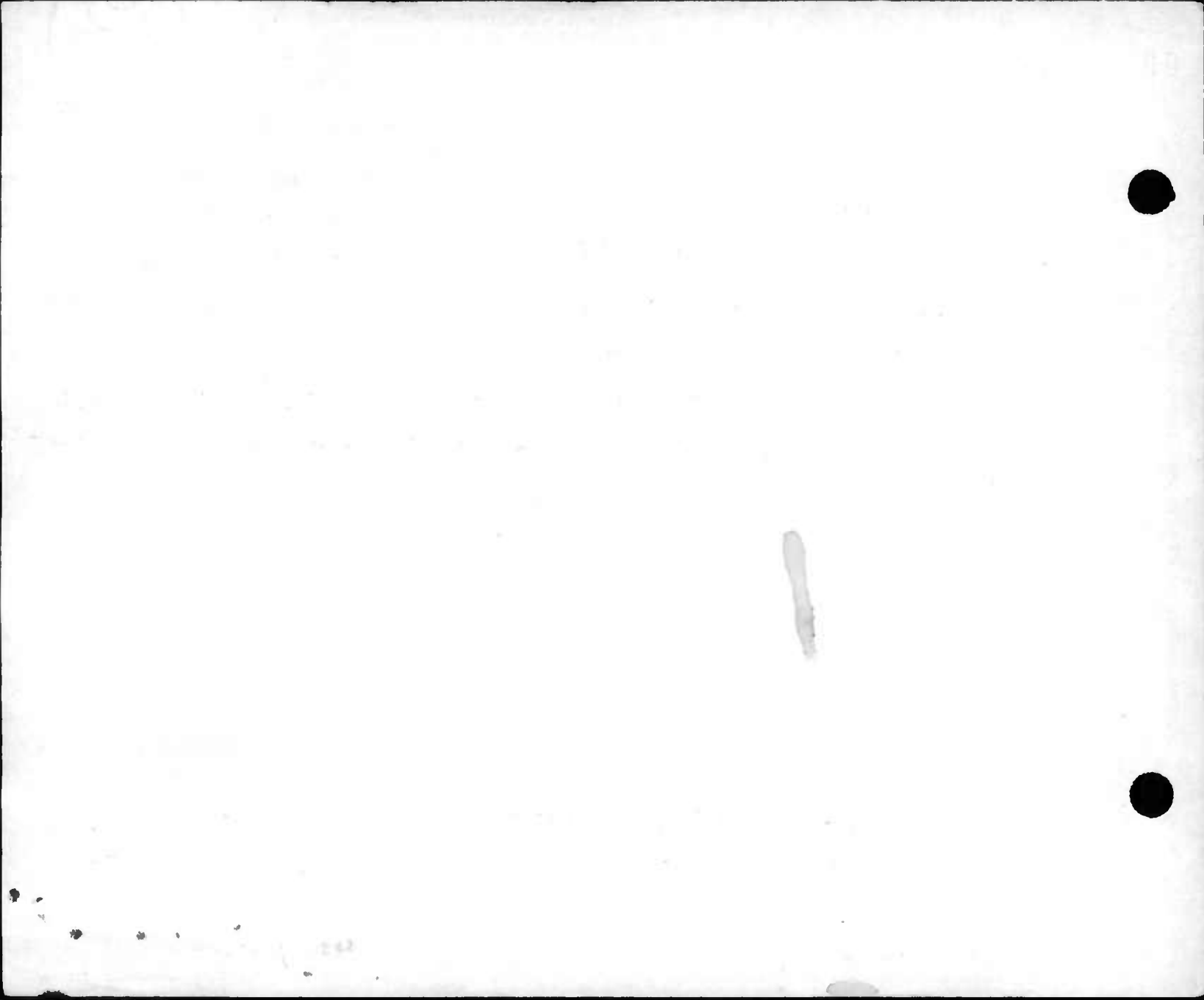
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

17174

| | | | | | | | |
|--|--|---|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Emmitt F McKinnon</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>6 30 86</i> | | 2b. HOUR
<i>0050 M</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1 - 9 - 30</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
<i>56</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Gaithersburg</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Shady Grove Adventist Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Maintenance - Ret</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Mfg.</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Gaithersburg</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
<i>17218 King James Way 20877</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Arthur McKinnon</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Rosie Byrd</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | |
| 16b. SOCIAL SECURITY NO.
<i>229-32-6713</i> | | 17. INFORMANT
ADDRESS
<i>Zillie B. McKinnon 17218 King James Way Gaithersburg, MD 20877</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>NA</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>NA</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE
<i>Frank Listello</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>6/30/86</i> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>FRANK LISTELLO</i> | | | | 22e. ADDRESS
<i>5644-EX Rockville, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>7-3-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rose Lawn Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Marion Smyth VA</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>M. M. Brown</i> | | | | 25. DATE RECEIVED BY REGISTRAR
<i>JUL 10 1986</i> | | 26. REGISTRAR'S SIGNATURE
<i>Julia Gordon</i> | |



00-11094

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 17775

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST JACKIE
MIDDLE MARIE
LAST MCKENZIE | | 2a. DATE KNOWN OF
DEATH | | MONTH DAY YEAR | | 2b. HOUR
M | |
| 3. SEX
F | | 4. RACE
W. | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | 7c. DATE
PRONOUNCED
DEAD | |
| 8. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. HOUR
M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | 13. HOUR
M | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS | |
| 16a. No | | 16b. - - - | | 16c. - - - | | 16d. 215-84-4722 | | 17. Louisa E. McKenzie
4425 Sime St.
Columbus, Ga. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Seizure Disorder</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | M.D. | | MEDICAL EXAMINER | | DATE
SIGNED | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | John Rogers, M.D. | | ADDRESS | | Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 7/2/86 | | St. Peter's Cem | | Waldorf, Charles, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME | | P.O. Box 156 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Huntt Funeral Home | | Waldorf, Md 20601 | | JUL 1 - 1986 | | John Rogers | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84
25MBP
DHMH - 17
(VR A15 ME (5))

2025

00-09941

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 7 6

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) EDNA | | FIRST Edna MIDDLE B. LAST McMullen | | 7a DATE OF DEATH
MONTH 6 DAY 11 YEAR 86 | | 7b HOUR
12:15 AM | |
| 3 SEX
F Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH 3 DAY 25 YEAR 95 | | 6 AGE (IN YEARS LAST BIRTHDAY)
91 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
M. D Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bel Air Health Care Center | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b KIND OF BUSINESS OR INDUSTRY
Navy Dept. | |
| 13a STATE
MD | | 13b COUNTY
Mont | | 13c CITY OR TOWN
Silver Spring | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST Charles MIDDLE Kleinhenn LAST Sophie | | 15 MOTHER'S MAIDEN NAME
FIRST Sophie MIDDLE Schurger LAST Schurger | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWI | | | |
| 16b SOCIAL SECURITY NO.
262-82-5468 | | 17 INFORMANT
ADDRESS
Donald K. McMullen Same as item # 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 70a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 70b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/10 80 to 6/11 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
R. I. Benack mo | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
6/11/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
R. I. Benack mo | | 22e ADDRESS
4115 Colie Dr. Wheaton, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SP)
Burial | | 23b DATE
6/13/86 | | 23c NAME OF CEMETERY OR CREMATORY
Parklawn Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Rockville, MD | |
| 24 FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 WI Ave. NW Wash., DC 20016 | | | | 25 JUN 10 1986 REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14920-0

Office:

200 COTTON MARKET

1000

1000



00-10298

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 7 7 7

REG. NO.

| | | | | | | |
|---|--|--|---|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JANE, Anne MC PEAKE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06-23-86 | | 2b. HOUR
10 AM | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 11 1899 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | |
| 7a. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sharon Nursing Home | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE
Maryland | | 12b. COUNTY
Montgomery | | 12c. CITY OR TOWN
Silver Spring | | |
| 12d. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Watson Murphy | | 12e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12f. STREET ADDRESS / ZIP CODE
212 Bryants Nursery Rd. 20904 | | |
| 12g. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Florence Buttermore | | 13. SOCIAL SECURITY NO.
198-32-3650 | | 14. INFORMANT
William McCaffrey -nephew-(same as 13e) | | |
| 15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke / Cerebral Vascular Accident | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one hour | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis / Previous Stroke | | DUE TO, OR AS A CONSEQUENCE OF | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cancer of Breast | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 5, 19 85, to June 23, 19 86, that (I) (we) last saw the deceased alive on June 20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Samuel L. Deshay MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/23/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL L. DESHAY, M.D. | | 22e. ADDRESS
7610 CARROLL AVE, TAKOMA PARK MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-27-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Spring Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Canonsburg PA. | | 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows only injury, or other traumatic event, the medical examiner will be notified at once.

BP

100-100-00

100-100-00

100-100-00

100-100-00

100-100-00

00-09879

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must view the injured person.

BP

DHMH-16 50M 1/B1
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| Elizabeth Veech Matthews Meehan | | June 17 1986 | | 7:30 P.M. | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | Caucasian | Oct 19 07 | 78 YRS. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Missouri | U.S. | | Montgomery County, MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Rockville | 759 Azalea Drive | Homemaker | | Own Home | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | zip: 20850 | | | |
| MD | Montgomery | Rockville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 759 Azalea Dr. | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William Matthews | | Eva Brooks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 219 48 515 | | Mr. Robert M. Meehan, Husband, Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency and Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 78</u> to <u>June 17 1986</u> , that (I) (we) last saw the deceased alive on <u>June 16 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| James J. Foster M.D. | | | | | | 6/17/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| James J. Foster M.D. | | 916 19th N.W. | | Wash D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | June 20, 1986 | | St. Mary's Cemetery | | Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD. | | | | JUN 19 1986 | | | | | |

MEDICAL CERTIFICATION

Station No. 11111111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17779
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
GENEVIEVE IRENE MELENDY | | 2a. DATE OF DEATH MONTH DAY YEAR
6-22-86 | | 2b. HOUR
11 56 PM M | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
4 12 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
82 Y | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SWITCHBOARD (RET) | | 12b. KIND OF BUSINESS OR INDUSTRY
GENERAL CONFI | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. STREET ADDRESS / ZIP CODE
15450 THOMPSON RD SS 20904 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EVAR MELENDY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
NETTIE MORRISON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-74-4705 | |
| 17. INFORMANT ADDRESS
IDAMAE MELENDY 15450 THOMPSON RD SS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive lung disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/11/86, 1986, to 6/22/86, 1986, that (I) (we) last saw the deceased alive on 6/22/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-23-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SMITH Ho, M.D. | | 22e. ADDRESS
7610 Carroll Ave Takoma Park Md 20912 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JUNE 25, 1986 | |
| 23c. NAME OF CEMETERY OR CREMATORY
PARKLAND CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ROCKVILLE MD | | 24. FUNERAL DIRECTOR
Takoma Funeral Home J.C. Walters | | 25a. DATE REC'D BY REGISTRAR
JUN 24 1986 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | 25c. ADDRESS
25V CARROLL DR NW DC | | 25d. DATE REC'D BY REGISTRAR
JUN 24 1986 | | 25e. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

00-11026

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 / 8 0
REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|--|---------------------------|--|--|---|------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Harold E. merritt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 20 86 | | 2b. HOUR
1032 M | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 20 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YEARS MONTHS DAYS
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
77 YRS. | | 8. IF UNDER 24 HRS
HOURS MIN.
1032 M | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 13. CITY OR TOWN OF DEATH
Takoma Park | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 15. USUAL OCCUPATION
(TYPE OF BUSINESS OR INDUSTRY)
Shipping & Receiving Clerk | | 16. KIND OF BUSINESS OR INDUSTRY
Railroad | | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Pa. 13b. COUNTY Blair 13c. CITY OR TOWN Altoona | | | | | | 18. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 19. FATHER'S NAME
FIRST MIDDLE LAST
Lloyd - Merritt | | | | | | 20. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mila - Nash | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | | | | 22. SOCIAL SECURITY NO.
716-05-8390 | | | | | |
| 23. INFORMANT
Ralph Olivio | | | | | | 24. ADDRESS
711 - 6th Ave., Altoona, Pa. 16602 | | | | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of Bladder and Malnutrition | | | | | | | | | | | |
| 26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
96 hrs.
3 months
12 months | | | | | | | | | | | |
| 27. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Chronic Obstructive Lung Disease, Atherosclerotic Heart Disease | | | | | | | | | | | |
| 28a. DATE OF OPERATION
3/10/86 | | 28b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ureteralileostomy for carcinoma of bladder | | 28c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 28d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 29d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 29e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 29f. LOCATION
STREET CITY OR TOWN COUNTY STATE
11700 Old Columbia Pike Silver Spring, Md. | | | | | | | |
| 29g. I certify that (I) (this hospital) attended the deceased from 6/19 1986 to 6/20 1986 , that (I) (we) last saw the deceased alive on 6/19 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 29h. SIGNATURE
Alan R. Gair MD | | | | | | 29i. DEGREE
MD | | | 29j. DATE SIGNED
6/20/86 | | |
| 29k. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN R. Gair MD | | | | | | 29l. ADDRESS
11700 Old Columbia Pike Silver Spring, Md. | | | | | |
| 30a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 30b. DATE
6/23/86 | | 30c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 30d. LOCATION
CITY OR TOWN COUNTY STATE
Altoona, Blair Penn. | | | | | |
| 31. FUNERAL DIRECTOR
NAME
Santella Funeral Home-Altoona, Pa. 16602 | | | | | | 32. DATE REC'D. BY REGISTRAR
JUN 25 1986 | | | | | |
| 33. REGISTRAR'S SIGNATURE
John R. Gair | | | | | | 34. REGISTRAR'S SIGNATURE
John R. Gair | | | | | |

MEDICAL CERTIFICATION

1250 1940

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00-09721

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17781
REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Isabel P. Middlekauff | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 2 '86 | | 2b. HOUR
6:50 a.m. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 31 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Music & Choir | 12b. KIND OF BUSINESS OR INDUSTRY
Church | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James L. Primm | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary - Hassinger | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
217-32-2076 | | |
| 17. INFORMANT
Leland H. Smith | | | ADDRESS
5802 Ryland Drive, Bethesda, Md. 20817 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) A.S.H.D. & C.H.F
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerosis,
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1973 to 6-2 1986 , that (I) last saw the deceased alive on 6-2 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view the body after death. | | | | | |
| 22b. SIGNATURE
Jack Schumacher M.D. | | | | 22c. DATE SIGNED
6-3-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Schumacher, M. D. | | | | 22e. ADDRESS
105 Russell Ave., Gaithersburg, Md. 20877 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Prince Geo. Md. | | 24. FUNERAL DIRECTOR
Roscoe H. Sandison 316 E. Diamond Ave.,
Gartner Sandison F. H. Gaithersburg, Md. 20877 | | | |
| 25. DATE REC'D BY REGISTRAR (S) REGISTRAR
JUN 06 1986 | | | | | |

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00-11028

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 1 8 2
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---------------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) AGNES E. Mills | | | 2a. DATE OF DEATH
MONTH 6 DAY 19 YEAR 1986 | | | 2b. HOUR 1735 | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH 3 DAY 27 YEAR 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHAW GROVE ADVENTIST Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DICKERSON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST HERMAN MIDDLE LAST ZIEHAN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST TAAFFE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-80-1871 | | 17. INFORMANT
ADDRESS - SAME -
JOSEPH M MILLS DICKERSON MD. | | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio-Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia extensive / Cancer spread
DUE TO, OR AS A CONSEQUENCE OF
(c) Breast Cancer / Metastases. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/11/86 19 86 , to 6/19/86 19 86 ; that (I) (we) last saw the deceased alive on 6/11/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. O. Whaney | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HIRSH D. WHANEY | | | | 22e. ADDRESS
20428 Germantown Rd, Germantown MD | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
6-23-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARY'S | | 23d. LOCATION
CITY OR TOWN BARNESVILLE COUNTY MONTGOMERY STATE MD | |
| 24. FUNERAL DIRECTOR
NAME W.C. HILTON | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 25 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-11080

FILED

100-11080

RECEIVED
JAN 10 1964
FBI - NEW YORK

TO DIRECTOR, FBI (100-334354) FROM NEW YORK (100-11080) 1P

RE NEW YORK TELETYPE TO BUREAU, JANUARY 9, 1964.

ADVISE THAT THE ABOVE NAMED INDIVIDUAL IS CURRENTLY IN THE CUSTODY OF THE NEW YORK POLICE DEPARTMENT.

THE NEW YORK POLICE DEPARTMENT IS CURRENTLY CONDUCTING AN INVESTIGATION INTO THE MATTER.

THE RESULTS OF THE INVESTIGATION WILL BE FURNISHED TO THE BUREAU AS SOON AS AVAILABLE.

VERY TRULY YOURS,
J. Edgar Hoover

WILLIAM J. RAY
Special Agent in Charge

100-11080

00-08585

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

URGENT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 8 1 7 1 8 3 | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Gabriel Mitchell | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 2 86 | | 2b. HOUR
5:04 A.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 18, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PUERTO RICO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRANSLATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CENSUS DEPT. | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PRINCE GEORGES | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1118 LANCASTER ROAD 20912 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACOB MICHEL | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CARLOTTA DomPIERRE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-60-6963 | | 17. INFORMANT ADDRESS
CARLINA STEELE, DAUGHTER, SAME AS ITEM #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) ACIDOSIS + PNEUMONIA | | | | | | | | 7 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE | | | | | | | | chronic | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | | | | |
| 9a. DATE OF OPERATION | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 19 84 , to present , 19 86 , that (I) (we) last saw the deceased alive on 30 MAY 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 27b. SIGNATURE
Patricia Gurny MD | | | | DEGREE
MD | | | | 27c. DATE SIGNED
6-2-86 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
PATRICIA GURNY, MD | | | | 27e. ADDRESS
11161 New Hampshire Ave, SILVER SPRING, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
6/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 5 1986 | | 25b. REGISTRAR'S SIGNATURE
John David Randall | |

BP

20200-2

| | | | | | |
|---------------------------------|--|------------------------|--|-------------------------------------|--|
| NAME | | WHITE | | BORN 12, 1900 | |
| FEDERAL BUREAU OF INVESTIGATION | | U. S. DEPT. OF JUSTICE | | WASHINGTON ADVISORY BOARD | |
| MARITAL STATUS | | SINGLE | | 1111 E. 12th St. S.W. | |
| EDUCATION | | HIGH SCHOOL | | 1111 E. 12th St. S.W. | |
| NO. | | 272-60-2463 | | EMERSON STREET, DALLAS, TEXAS 75211 | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-01 BY 60322 UCBAW/BJS

00-09058

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 7 7 8 4
REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HARRY MONSEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 8 86 | | 2b. HOUR
2 45 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 19 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7108 Nevis Rd., Bethesda, Md | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Business Owner (ret) Pvt. School | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Florida | | 13c. CITY OR TOWN
Dade Miami Beach | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
19390 Collins Ave., #1606/33160 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Max -- Moonshine | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah -- Green | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
168-05-3315 | | 17. INFORMANT
ADDRESS
Irwin S. Monsein 7108 Nevis Rd., Md. 20817 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutesYears

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/6</u> , 19 <u>85</u> to <u>6/6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Alexander Chester</i> | | DEGREE
MD. | | 22c. DATE SIGNED
6/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alexander Chester | | 22e. ADDRESS
3301 New Mexico Ave., NW, Washington, DC | | 22f. MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/> | |

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6-10-86 | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. Falls Church | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Virginia |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Mem Chps | | 25a. DATE REC'D. BY REGISTRAR
JUN 12 1986 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

16 JUN 7/84
RA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



0-08491

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17785

| | | | | | | | | | | |
|--|--|--|--|---|-------------|---|---|--|--------------------|-------------------------------|
| 1. FOR STATE REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | FIRST
FREDRICK | MIDDLE
H | LAST
MORRIS, SR. | 2a. DATE OF DEATH
MONTH DAY YEAR
June 1, 1986 | | 2b. HOUR
0406 M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 7, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CHICAGO, ILL. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sunny Grove Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CHEMICAL PLANT | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
GAITHERSBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
18213 LOST KNIFE CIRCLE 20879 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FREDRICK - MORRIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GRACE - HEPBURN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
328-05-4893 | | 17. INFORMANT ADDRESS
RITA L. MORRIS SAME AS # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmias</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>Ischemic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES Mellitus.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Gregory H. Fisher</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gregory H. Fisher | | 22e. ADDRESS
13-15 East Deer PK Drive
GaitHERSBURG MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JUNE 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | | 23d. LOCATION
SILVER SPRING MONT. MD. | | | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | |

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "THE" and "FOR" are visible.]

00-10363

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 3- SEX
Female | | 4- RACE
White | | 5- DATE OF BIRTH
February 29, 1912 | | 6- AGE (IN YEARS LAST BIRTHDAY)
74 | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ruby Rebecca Moss | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 18, 1986 | | 2b. HOUR
11:17A _M | | 7- BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
C&P Telephone Co | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Mt. Rainier | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3000 Arundel Road, Apt. #2 20712 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John D. Cooper | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Harriett J. Branham | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
577-01-3579 | | 17. INFORMANT
ADDRESS
Benjamin F. Moss (Husband) Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>86</u> to <u>6/10</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) two (and) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Surinder Singh</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>6/18/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Surinder Singh, M.D. | | | | 22e. ADDRESS
4713 Berwyn Road, College Park, Md. 20740 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
06/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Maryland | | 23e. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781 | |
| 24. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | | | 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

BP _____

20801

For the purpose of the survey of the land of the United States, the following is a list of the names of the persons who have been employed in the survey of the land of the United States, and who have been paid for their services.

Surveyors

Assistants

Agents

Deputies

Inspectors

Commissioners

Surveyors

Assistants

Agents

Deputies

Inspectors

Commissioners

Surveyors

Assistants

Agents

Deputies

Inspectors

Commissioners

Surveyors

Assistants



1880

0-0981.9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17787

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT) Gizella A MURRAY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-12-86 | | 2b. HOUR
10 PM |
| 3 SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 7, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wheaton Manor Care | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
14502 Faraday Drive 20853 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Andrew Koczan | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen Stolarich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-20-9759 | 17. INFORMANT
Son Ronald K. Murray ADDRESS P.O. Box 371 Franklinton, La. 70438 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular system | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6/12/86 |
| DUE TO, OR AS A CONSEQUENCE OF
(b) CVA | | 1986 |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CAD, LVE | | 1583 |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Arteriosclerosis**

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION
6/12 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
SC | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
18111 Prince Philip Rd 20852 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22c. DATE SIGNED
6/22/86 | |
| 22b. SIGNATURE
Arthur Swygger | | 22d. ADDRESS
18111 Prince Philip Rd 20852 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur Swygger | | 22f. ADDRESS
18111 Prince Philip Rd 20852 | |

| | | | |
|---|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 16, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Maryland |
| 24 FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall |
| 500 University Blvd., W. Silver Spring, Md. | | | |

1871

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11 11 11

11 11 11

NOTION & CO

WICKHAM



0-11399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner will not be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 86 17 / 88 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
DORA Dorothy NATHANSON | | | | 2a. DATE OF DEATH
6 30 1986 3 ⁰⁰ P.M. | | | |
| 3. SEX
F FEMALE | | 4. RACE
W WHITE | | 5. DATE OF BIRTH
7 16 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
XXXXXX ABRAHAM BANKS | | | | 15. MOTHER'S MAIDEN NAME
XXXXXX YETTA UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-32-2295B | | 17. INFORMANT
Arlene Nathanson 3211 Woodvalley Baltimore #21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes, Dementia</u> | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital (or) attended the deceased from <u>5/22</u> 19 <u>85</u> to <u>6/30</u> 19 <u>86</u> that (1) we last saw the deceased alive on <u>6/30</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond Bass | | | | DEGREE
MD | | 22c. DATE SIGNED
6-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | | 22e. ADDRESS
3941 Ferrara Wheaton Md 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JULY 2, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH | | 23d. LOCATION
BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
601C REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 5 - 1986 | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | |

BP

12/12

00-09215

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617189

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Henry T. Neal | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 2, 1986 | | 2b. HOUR
A M
10.00 |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4-26-15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
STATE OR FOREIGN
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY
DMV |
| 13a. USUAL RESIDENCE
13a. STATE
13b. COUNTY
13c. CITY OR TOWN
Md Montg Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
715 Lenmore Ave #344 20850 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry T. Neal | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie A. Taylor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 218-05-4240 | | 17. INFORMANT
ADDRESS
B. Eugene Neal 452 Bostwick Lane
Gaithersburg, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC ADENOCARCINOMA of COLON
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Susan D. Allen MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6-7-86 | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sugarland, Montg. MD | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 24b. ADDRESS
246 N. Washington
Rockville, MD 20850 | | 25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
20850 051986 Julia Gardner-Randall | |

00-00012

0

Handwritten notes and stamps, including "RECEIVED" and "FEB 1964".

Handwritten notes and stamps, including "RECEIVED" and "FEB 1964".

Handwritten notes and stamps, including "RECEIVED" and "FEB 1964".

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|-----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR
1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
EVELYN LOUISE NELSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JUNE 27 1986 | | | | | 2b. HOUR
12:56 A | | | |
| 1a. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 9 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
PRINCE GEORGE'S | | 13c. CITY OR TOWN
HYATTSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
8316 14th AVENUE Apt. 101 20783 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HERMAN WILLIAM MOORE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LUCY KATHLEEN HURDLE | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
579-38-4251 | | 17. INFORMANT
SON | | ADDRESS
APT. 101 20783 | | | | | |
| | | | | | | GEORGE A. NELSON, 7909 KREEGER DRIVE, ADELPHI, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 17 , 19 86 , to JUNE 27 , 19 86 , that (I) (we) last saw the deceased alive on JUNE 27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>M. Pierdinock</i> | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
27 Jun 86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. PIERDINOCK, LCDR, MC, USNR | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
July 1, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Cemetery Arlington National | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Collins, Jr. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 7 1986 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | | | | | | | | | |
| 25c. ADDRESS
500 University Boulevard West Silver Spring, Md. | | | | | | | | | | | | | |

0-1551

101.20A



00-09738

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17791

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorothy S. Newman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 11, 1986 | | 2b. HOUR
9:40 p.m. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 18, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward V. Schenck | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clementine Sulphin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-34-2773 | | 17. INFORMANT ADDRESS
L. Reed Miller 5200 Dorset Ave. Chevy Chase, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Endocarditis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Congestive Failure | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
Renal Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 21g. I certify that (I) (XXXXXX) attended the deceased from 05/23/86 19 to 06/11/86 19, that (I) (XX) last saw the deceased alive on 06/11/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (XXXXXX) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
Miguel A. Rodriguez | | DEGREE
M.D. | | 22b. DATE SIGNED
6/17/86 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
MIGUEL A. RODRIGUEZ | | 22d. ADDRESS
831 University Blvd. S. Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 14/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, P.G. Co., Maryland | | 23e. ZIP CODE
20903 | | | |
| 24. FUNERAL DIRECTOR
NAME
Chambers Funeral Home | | ADDRESS
Silver Spring, Maryland | | 25a. DATE RECEIVED BY REGISTRAR
JUN 17 1986 | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Robert | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner may be notified at once.

00-10344

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17792

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel W. Newsom | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 19 86 | | 2b. HOUR
12:30 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 14 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Pk. Md | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp- Takoma Pk. Carroll Ave | | 12a. USUAL OCCUPATION
(TYPE OF WORK AND MOST OF WORKING HRS)
Adm. Asst. N.I.H. U.S. Govt. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE
MD | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
1722 Franklin Ave, 20902 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Holtzapple | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Brewer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A 184-20-0920 | | 17. INFORMANT ADDRESS
Bobbie T. Newsom-husband- (same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Duodenal Adeno Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
1 Chronic Renal Failure 2 Arterio sclerosis 3 Myocardial Aortic Aneurysm | | | | | |
| 19a. DATE OF OPERATION
5/18/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
UGI Bleeding | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/14 19 86 to 6/19 19 86 that (1) (we) lost
saw the deceased alive on 6/18 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jeffrey D Robis | | DEGREE
MD | | 22c. DATE SIGNED
6/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEFFREY D ROBIS | | 22e. ADDRESS
10500 Summit Ave
BETHESDA MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6-23-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring Montgomery Md. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home 11800 N.H. Ave. Silver Spring, Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 may be retained by the funeral director, or the funeral home, or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

12

13

14

15

A

10-10584

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17793
REG. NO.

| | | | | | | | |
|--|--|--|--|---|----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John (NMI) Nolen, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 20, 1986 | | 2b. HOUR
2:25A.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 28, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6009 Benalder Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
City Planner | | 12b. KIND OF BUSINESS OR INDUSTRY
D.C. Gov't. | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John --- Nolen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara --- Schotte | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW I 578-58-6578 | |
| 17. INFORMANT
John C. Nolen, 2 Park Overlook Ct, Beth., Md. | | 18. ADDRESS
6009 Benalder Dr./20816 | | 19. STREET ADDRESS / ZIP CODE | | 20. CITY OR TOWN / STATE | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1986</u> to <u>June 1986</u> , that (I) (we) lost
saw the deceased alive on <u>June 10, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>F.P. Smith</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
June 20, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederick P. Smith | | | | 22e. ADDRESS
5401 Western Ave, NW, Washington, D.C. 20015 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, VA | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 26 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 above, any injury, or other traumatic event, the medical examiner must be notified of office.

100-10000

(MIL)

Feb. 28, 1938

U.S.A.

X

City Planner

Mayor

Mayor

6003 Senator Dr. (SOS)

Montgomery, Alabama

MD

Scholar

--

Lawyer

John

--

John

John O. Nolan, 2 Park Overlook Ct, Bethesda, Md.

258-2-4778

Mr. J

Yes

Alexandria, VA

Mt. Comfort Cemetery

Joseph G. Grier's Sons, Inc.

2130 Wisconsin Ave, N.E., Washington, D.C. 20002

00-10631

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17794

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Emma Therese Noll | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 21, 1986 | | | 2b. HOUR
7 P M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 2, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Switzerland | | 7b. CITIZEN OF WHAT COUNTRY?
Switzerland | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5913 Rossmore Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
1208, Geneva, Switzerland | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Foyer St. Paul
40 Chemin Frank - Thomas | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emil Bettems | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Henriette Bovy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
ADDRESS
Richard Noukelak, 5913 Rossmore Dr, Bethesda, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of lung</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 84</u> to <u>June 19, 86</u> , that (and we) last saw the deceased alive on <u>June 19, 86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
MARVIN WADLER | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARVIN WADLER | | | | | | 22e. ADDRESS
8218 WISC. AV. BETH. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
6/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY
J. Wm. Lee's Sons Co. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME
McGuire Funeral Service, 7400 Georgia Ave. N.W. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 26 1986 | | | |
| ADDRESS
Washington, DC | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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10000-00

QND

WAFH



5000 10000

00-08487

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/B2
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17797
REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | Grace C. Nye | | June 1, 1986 | | 11:30am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | September 12, 1890 | | 95 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| New York | | U.S.A. | | | | Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Kensington | | Kensington Gardens Nursing Home | | Homemaker | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Theodore - Comfort | | Mary F. Walters | | No | | None | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Robert W. Nye (Son) Same as # 13. | | Carcinoma base of pancreas | | | | | |
| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | > 2 mos | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | | | P.M. 19 | |
| | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | 22a. SIGNATURE | | 22b. DATE SIGNED | |
| | | | | Dr. David B. Kessler, M.D. | | June/2/86 | |
| | | | | 22c. ADDRESS | | | |
| | | | | 10620 Georgia Ave. Silver Spring, Md. | | | |
| | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| | | | | Cremation | | JUNE 2, 1986 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | Chambers Crematory | | Riverdale, P.G. Co., Maryland | |
| | | | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| | | | | Chambers Funeral Home Silver Spring, Maryland | | JUN 4 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | John Davidson | | | |

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

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1990-1991

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00-10002

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17798

| | | | | | | | |
|--|--|---|---|---|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ernest E. Offutt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 14, 1986 | | 2b. HOUR
10:31 AM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 29, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Clarksville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
14034 Brighton Dam Rd. 21029 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
James Offutt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elsie Mitchell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
217-32-1977 | | 17. INFORMANT
ADDRESS
Ethel C. Offutt (wife) same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonitis (pending Aut.)
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION
6/13/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Osteoarthritis of knee | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE
John Delahay MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 23b. DATE SIGNED
6/14/86 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
John Delahay MD | | 23d. ADDRESS
1811 Prince Philip Dr. Oakley Md. 20884 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mutual Mem Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring, Montg. MD | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | ADDRESS
Rockville, MD | | 25a. DATE REC'D. BY REGISTRAR
JUN 19 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Landers | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

0-10003

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20% COTTON FIBER

100% COTTON FIBER



00-10405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Joseph Michael Ontko | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
June 17 '86 | | 2b. HOUR
7 a. M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 19 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12 So. Frederick Ave. #206 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanical Insp. | | 12b. KIND OF BUSINESS OR INDUSTRY
Engineering | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
12 So. Frederick Ave. (20877) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Andrew John Ontko | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine Margaret Hurtuk | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | |
| 16b. SOCIAL SECURITY NO.
292-10-8978 | | | 17. INFORMANT ADDRESS
Maria M. Ontko 12 So. Frederick Ave. #206 Gaithersburg, Md. 20877 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/24 19 86 to 6/17 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 6/13 19 86 , and that in (my) <input checked="" type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stephen Newmann DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Newmann, M.D. | | | | 22e. ADDRESS
19261 Montgomery Village Ave., Gaithersburg, Md. 20879 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring Montg. Md. | | | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 20 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Sandison | | | |

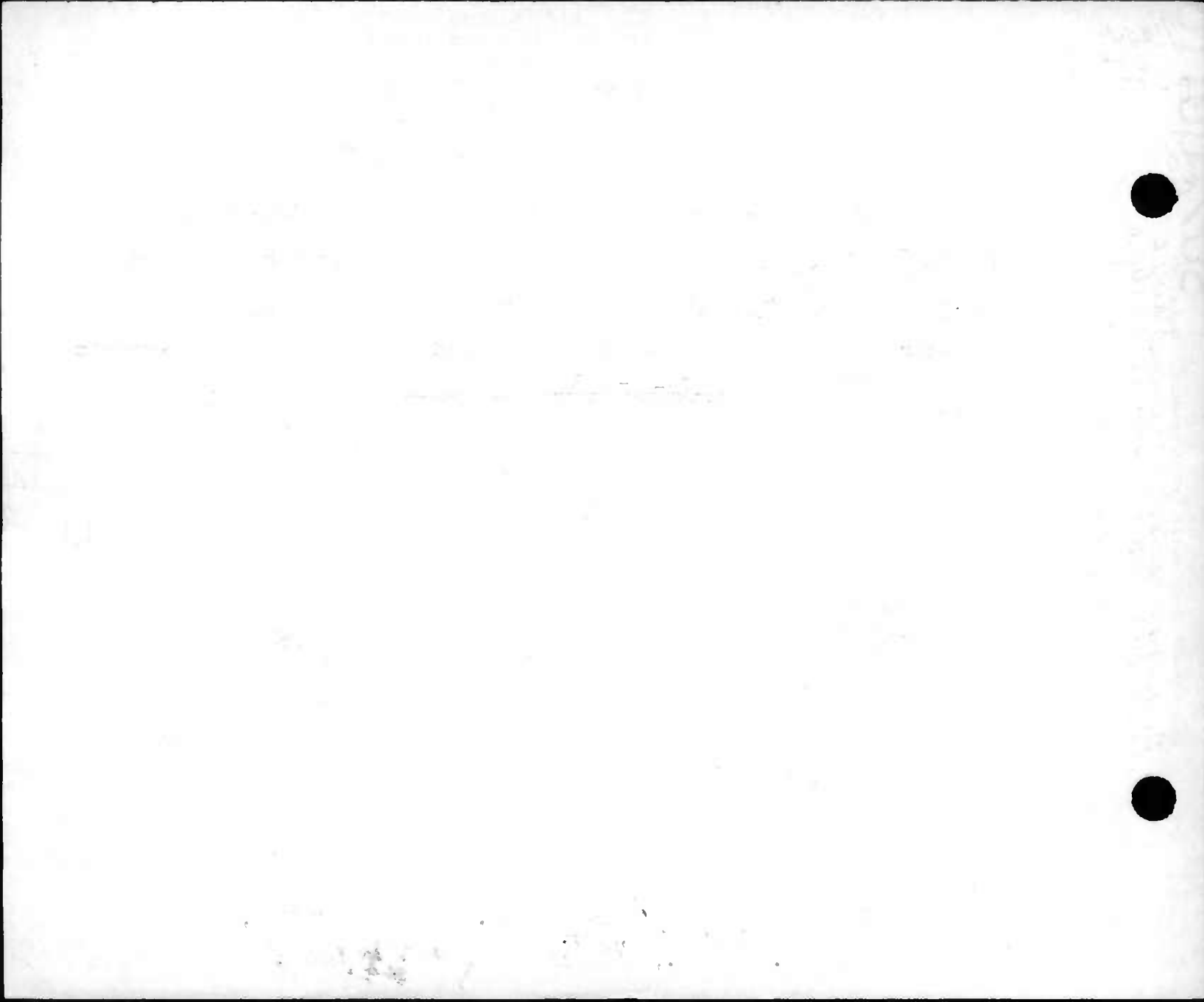
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0-09214

Rever
622-1645

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Dr. Rogers contacted by phone for Dr. Stanley
Dr. Rogers seen by me for Dr. Stanley
TO HOSPITAL OR ATTENDING PHYSICIAN requires that the death certificate be dictated within 24 hours after death and be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| FOR
1 - STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 7 6 1 7 3 0 0 | |
|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST Julia MIDDLE Panor LAST PANOR | | MONTH 6 DAY 1 YEAR 86 | | 7:35 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| FEMALE | CAUC. | MONTH 5 DAY 5 YEAR 1895 | 91+ | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| GREECE | USA | | Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | Sylvan Manor Health Care | | Homemaker | | Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | | |
| MD | Montg. | Chevy Chase | 5100 Dorset Ave. 20815 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST Peter MIDDLE LAST Conostas | | FIRST Maria MIDDLE LAST Mavradia | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | X 5130-74-3951 | | Anna Panor Same as item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Respiratory arrest | | | | | immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral infarct | | | | | 1 1/2 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral atherosclerosis | | | | | years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| none | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/1/86, 1986, to 6/1, 1986, that (I) (we) lost | | | | | |
| saw the deceased alive on 6/1/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Allen J. O'Neill MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 6/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Allen J. O'Neill MD | | 8601 Old Georgetown Rd., Bethesda, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 6/4/86 | Parklawn Cem. | Rockville, MD | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME 5130 WI Ave. NW Wash., DC 20016 ADDRESS | | JUN 14 1986 | | John Taylor | |



00-08584

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17301
REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Benjamin P. Payne JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-2-86 | | 2b. HOUR
10⁴⁵ AM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 14, 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
29 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSP'T. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COMPUTER OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
COMPUTERS |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
P.G.C. | 13c. CITY OR TOWN
RIVERDALE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
5713 SOMERSET RD. 20737 | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET J. BARTON | | |
| 16a. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN P. PAYNE SR. | | | 16b. SOCIAL SECURITY NO.
219-64-4185 | | |
| 17. INFORMANT
ADDRESS
BENJAMIN P. PAYNE SR. (SAME AS ITEM #13) | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Nephrotic Renal Sm
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/30/1986 to 6/2/1986 , that (I) (we) last saw the deceased alive on 6/1/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Tony P. KANNARKAT | | DEGREE
MD | | 22c. DATE SIGNED
6/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Tony P. KANNARKAT | | 22e. ADDRESS
8201 16th ST S.S. MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
6-5-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD, P.G.C. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
W. W. CHAMBERS CO. RIVERDALE, Md. 20737 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 5 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

BP

WASHINGTON, D.C.

U.S.A.

AMERICAN

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

AMERICAN

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

AMERICAN

UNITED STATES DEPARTMENT OF JUSTICE

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

AMERICAN

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

AMERICAN

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 0 2
REG. NO.

| | | | | | | | |
|---|--|--|--|---|------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William E Paynter | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-26-86 | | 2b. HOUR
6 AM | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 21 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58
YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
PA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RECHART | | 12b. KIND OF BUSINESS OR INDUSTRY
GOUT. | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD PAYNTER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
P. LAKE | | 13e. STREET ADDRESS / ZIP CODE
5047 BRADLEY BLVD 20813 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
FNEZ PAYNTER | | ADDRESS
PHILA PA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute CARDIOPULMONARY Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) systemic CARCINOMATOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) bronchogenic CARCINOMA | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Steven D. Lerner | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN D. LERNER MD | | | | 22e. ADDRESS
1145 19th ST NW #802 WASHINGTON, DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
BETHEL | | 23d. LOCATION
CITY COUNTY STATE
CHESAPEAKE ECIL MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
R.I. FORD FUNERAL HOME CITY MD | | | | 25a. DATE REC'D BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 21 shows any injury, or other traumatic event, the medical examiner must be notified and given an opportunity to examine the body.



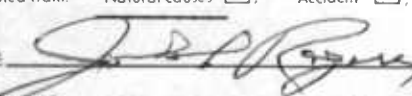

00-08493

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17803

| | | | | | |
|--|-------------------------|---|---|---|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Peter W. Peirce | | MONTH DAY YEAR
6/2 1986 | | M
9:45 A. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH (MONTH DAY YEAR)
May 18, 1921 | 6. AGE (IN YEARS) (LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
 | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
706 Gist Avenue | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CREDIT WORK | | 12b. KIND OF BUSINESS OR INDUSTRY
PRIVATE BUSINESS | | 13a. STREET ADDRESS
706 Gist Avenue | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EARL S. PEIRCE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DOROTHY BEACH | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
YES | |
| 16b. SOCIAL SECURITY NO.
W.W. II | | 17. INFORMANT
JOAN L. PEIRCE | | 17. ADDRESS
706 GIST AVE. S.S. MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
None | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
 | | 21f. LOCATION CITY OR TOWN COUNTY STATE
 | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Deputy | | DATE SIGNED
6/2/86 | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | ADDRESS
1919 Seminary Road Silver Spring, Montgomery County, Md. | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | |
| 23b. DATE
June 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore/Washington Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Laurel Md | |
| 24. FUNERAL DIRECTOR
Takem Funeral Home | | ADDRESS
250 Carroll St NW DC | | 25a. DATE RECD. BY REGISTRAR
JUN 4 1986 | |
| 25b. REGISTRAR'S SIGNATURE
 | | 25c. REGISTRAR'S NAME
John Davidson | | 25d. REGISTRAR'S ADDRESS
 | |

429

2008-2009

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0-08771

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17804

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY ELIZABETH PERKINS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 4 1986 | | 2b. HOUR
4:10 A |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
FEBRUARY 22 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
Never Worked |
| 13a. STATE
VIRGINIA | | | 13b. COUNTY
FAIRFAX | 13c. CITY OR TOWN
MCLEAN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
J. W. PERKINS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IRIS SHARPLES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
227-11-5069 | | 17. INFORMANT
ADDRESS
J.W. PERKINS, 6700 WEAVER AVENUE, MCLEAN, VA 22101 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 31 , 19 86 , to JUNE 4 , 19 86 , that (I) (we) last saw the deceased alive on JUNE 4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>J.P. Mehegan</i> | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
4 June 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.P. MEHEGAN, LT, MC, USN | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/09/'86 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
<i>Money & King</i> | | 24b. DATE REC'D. BY REGISTRAR
JUN 6 1986 | | 24c. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE

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Item #, G-618, 8/15/86 by
FOR request, /Gbj.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17805
REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mercedes A. E. Perry | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/28/86 | | 2b. HOUR
M
AM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 29 56 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., DC. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
29 | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
D.C. | | 13b. COUNTY
N | | 13c. CITY OR TOWN
Washington | |
| 4. FATHER'S NAME
FIRST MIDDLE LAST
John H. Perry | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara B. Jones | | 12b. KIND OF BUSINESS OR INDUSTRY
Manager | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
577 74 1821 | | 17. INFORMANT
ADDRESS
Clara B. Perry-mother | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiorespiratory collapse.
DUE TO OR AS A CONSEQUENCE OF
b) Severe Metabolic Acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
SPECIATE INTERNAL BETWEEN PART 1 AND PART 2 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/26 19 86 to 6/28 19 86 that (I) (we) last saw the deceased alive on 6/28 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the deceased after death, so state.) | | | | | |
| 22b. SIGNATURE
Steven Christian M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
6/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven Christian M.D. | | 22e. ADDRESS
344 University Blvd W Silver Spring Md | | | |
| 23a. BURIAL, CREMATION, ETC. (SPECIFY)
Burial | | 23b. DATE
July 3, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | |
| 23d. FUNERAL DIRECTOR
NAME
Stewart Funeral Home - 4001 Benning Road, NE | | 23e. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 - 1986 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, file medical certificate with the funeral director.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10-11-58

(A)

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | 86 17806
REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RUSSELL V. PERSON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
6/16/86 | | 2b. HOUR
10 49 AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
9/11/96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MINNESOTA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
Capital Inst. of Tech. | |
| 13a. STATE
MARYLAND | | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES PERSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA DAHLMAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
472-09-2753 | | 17. INFORMANT
DAUGHTER
LILAS P. WILTSHIRE
ADDRESS
SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE 1a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) ISCHEMIC HEART DISEASE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 HOURS
ONE YEAR | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/15, 1986, to 6/16, 1986 that (I) (we) lost saw the deceased alive on 6/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Daniel I Woronow MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
6/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL I WORONOW, MD | | | | 22e. ADDRESS
8830 CAMERON ST. SILVER SPRING, MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JUNE 20, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONTGOMERY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS, JR.
500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
John E. Rindell | |

2

STATE OF TEXAS

REVENUE DEPARTMENT

STATE OF TEXAS

0-10432

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17807

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Laa FIRST Phantha MIDDLE LAST | | | 2a. DATE OF DEATH
MONTH DAY YEAR 6 19 86 2b. HOUR 8¹³₂ AM | |
| 3. SEX
Male | 4. RACE
Asian | 5. DATE OF BIRTH
MONTH DAY YEAR 1 - 1 - 24 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Thailand | 7b. CITIZEN OF WHAT COUNTRY?
Thailand | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unknown | 12b. KIND OF BUSINESS OR INDUSTRY
unknown |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Takoma Park | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Laa MIDDLE LAST Phantha | | 15. MOTHER'S MAIDEN NAME
FIRST Unknown MIDDLE LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
577-06-7070 | | 17. INFORMANT
Tony Thone Phantha ADDRESS 8608 Flower Ave. Apt. A11 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Sephic Shock & Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Pleural effusion | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Jaundice, & Thrombocytopenia | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/81 19 86 to 6/19/86 19 86 , that (I) (we) last saw the deceased alive on 6/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Vivek C. Vaid | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VIVEK C VAID M.D | 22e. ADDRESS
3311 Talido Terrace Hyattsville Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
6/21/86 | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale P.G. Md. | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers, Co. | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | |
| ADDRESS
Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared with Dr. Rogers, Medical Examiner

58101-1

NOTICE FOR



00-09530

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 7 8 0 8

| | | | | | | |
|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Kathryn B Piper | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 10 86 | | 2b. HOUR
9:55PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 1 10 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
75 | | 8. IF UNDER 24 HRS
HOURS MIN.
75 | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Grosvenor Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
2914 Hardy Avenue 20902 | | 13b. CITY OR TOWN
Wheaton | | |
| 13c. STATE
Maryland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Lyle Abrams | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Adams | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
181-01-6347 | | |
| 17. INFORMANT
ADDRESS
Lynne A. Dixon Daughter Same As 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiovascular Accident | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular Disease | | DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 10 / 83 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
83 | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6/10 80 | | 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased on or about 6/10/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) use the body after death. | | 22b. SIGNATURE
Myron L. Lenkin | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | 22d. ADDRESS
2309 SHOREFIELD RD WHEATON, MD | | 22e. DATE SIGNED
6/11/85 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 12, 86 | | 23c. NAME OF CEMETERY OR CREMATORY
Philadelphia Memorial | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Malvern Pa. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd. West Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | | | | | |



EXHIBIT NOTED 2002



Page 10 of 10

10

00-09717

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17809

| | | | | | |
|--|--|---|--|--|--|
| 1- STATE REGISTRAR | | 2a DATE KNOWN OF DEATH | | 2b HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| William Nelson Poindexter Jr. | | M | | Black | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. DATE PRONOUNCED DEAD | |
| July 13 1935 | | 55 YRS. | | June 1 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Washington, D.C. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) | |
| Silver Spring | | Holy Cross Hosp | | Contract Specialist | |
| 13a. STATE | | 13b. COUNTY | | 13c. STREET ADDRESS | |
| Md | | Montgomery | | 9902 Grayson Ave | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| William Nelson Poindexter Sr. | | Jennie B. White | | 579-52-7786 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| yes | | 3/3/53-3/2/57 | | Julia Poindexter | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Chlorbromide</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) <u></u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u></u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| 22b. TITLE (SPECIFY) | | | | | |
| MEDICAL EXAMINER | | | | | |
| ACTUAL SIGNATURE | | DATE SIGNED | | | |
| JOHN B. Rogers | | June 1 1986 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| | | 1919 Seminary Rd. | | Silver Spring Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | June 5 1986 | | George Washington | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| McGuire Funeral Service | | June 5 1986 | | Julia Davidson-Poindexter | |
| NAME | | ADDRESS | | | |
| 7400 Georgia Ave. Washington, D.C. | | | | | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

USA .C.

US Contract Specialist

Julia Poindexter Sr. 579-25-7786
Jennie B. Whit

20th

00-10268

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17810

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Mary Agnes Poscy</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>6-7-86</i> | | 2b. HOUR
<i>8:30 A</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Black</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1-31-04</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Germanatown</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>19308 St. Johnsbury Lane</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housekeeper</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Domestic</i> |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>Montgomery</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Germanatown</i> | | 13d. INSIDE CITY LIMITS
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>19308 St. Johnsbury Lane 21930</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Harry Moore</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Carrie Chaney</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | 16b. SOCIAL SECURITY NO.
<i>578-26-6766</i> | 17. INFORMANT
ADDRESS
<i>Daughter - Hannah Waters same as above</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>ASCITOS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>metastatic Bowel Cancer</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>6/9/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Michael A. Blagnese, MD</i> | | 22e. ADDRESS
<i>19231 Montgomery Vill. Ave Gaithersburg MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
<i>BURIAL</i> | 23b. DATE
<i>6-10-86</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Brooke Grove Cem</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Laytonsville, Montg MD</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>George R. Smuden</i> | | ADDRESS
<i>Rockville, Md</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>23 JUN 1986</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05-10564



RECEIVED
JAN 10 1964

00-10242

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8617811

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Kenneth W. Prentice | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/18 86 | | 2b. HOUR
940P | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 30 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Own Practice | | 12b. KIND OF BUSINESS OR INDUSTRY
Dentistry | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William W Prentice | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Evelyn Streit | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | | |
| 16b. SOCIAL SECURITY NO.
220-12-4178 | | 17. INFORMANT Daughter Beltzville, Maryland 20705
Carol A. Taylor 11242 Cherry Hill Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hepatic failure
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
4 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
10/2 85 6/18 86 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18 86 , to 6/18 86 , that (I) (we) last saw the deceased alive on 6/18 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bruce A. Silver, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
6/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE A. SILVER, MD | | | | 22e. ADDRESS
106 IRVING ST. NW #94 WASHINGTON, DC 20010 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 21, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Montgomery Md. | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | | |

MEDICAL CERTIFICATION

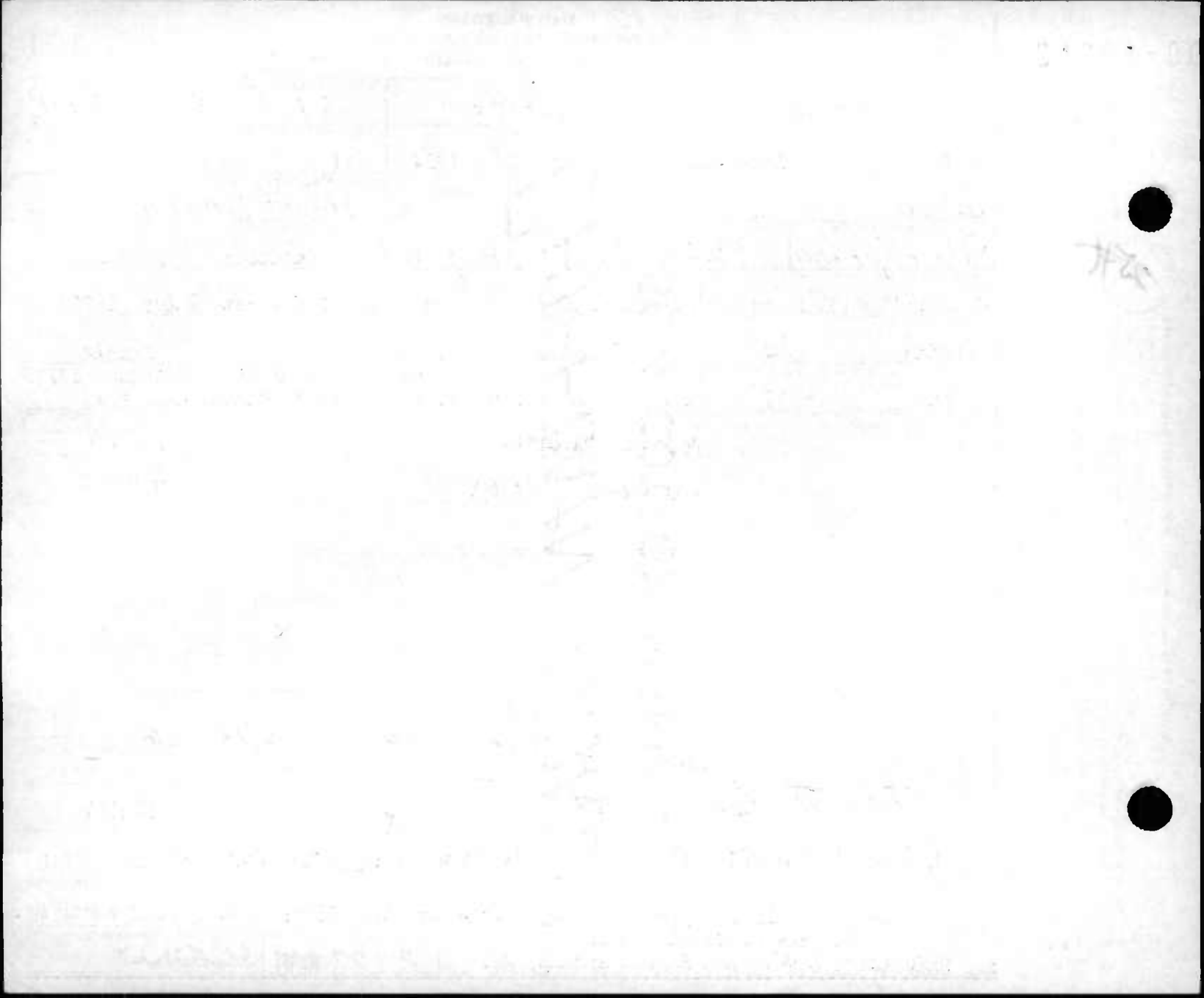
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



00-09818

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DOOLARIE | | Ramjattan | | | | | | 6 12 86 | | 7 39 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| F | | West Indian | | APRIL 30 1916 | | 70 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Trinidad | | Trinidad | | | | Montgomery | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Takoma PK | | DAH-TAKOMA PK, MD 20912 | | Homemaker | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Montgomery | | Takoma Park | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8608 Carroll Avenue | | 20912 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Sobha | | Mowsaie | | Roopania | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 215-78-6957 | | Daughter | | 11308 Schuylkill Rd | | | | | |
| | | | | Carmen Chee-You | | Rockville, Md. | | 20852 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) HYPOTENSIA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) SEPTICEMIA | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| PULMONARY FIBROSIS - PNEUMONIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 4/25/86 | | CORONARY ARTERY DISEASE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/25 19 86 to 6/11 19 86, that (I) (we) last saw the deceased alive on 6/11 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| S. NGIMAI, MD | | MD | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| S. NGIMAI, MD | | 10313 GEORGIA AV. | | | | | | | | | |
| | | SILVER SPRING, MD, 20902 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Burial | | June 13, 1986 | | George Washington | | Adelphi Pr. Geo. | | Maryland | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Francis J. Collins, Jr. | | JUN 18 1986 | | Julia Davidson Handell | | | | | | | |
| 500 University Blvd. W. | | Silver Spring, Md. | | | | | | | | | |

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X

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0-09791

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH 36 60M 7/84
(VKA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17813
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | June 15, 1986 | | 9:02PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Female | | Caucasian | | February 14, 1908 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Wisconsin | | United States | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Bethesda | | 5138 Massachusetts Ave. | | Abstractor | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Wisconsin Dane | | Madison | | 49 C. Golf Course Road 55704 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| J. P. Thelen | | not available Meice | | No N/A | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Daughter) | | ADDRESS | |
| 388-38-8194 | | MaryJane Reynolds | | 5138 Massachusetts Av Bethesda, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Pancreatic CA</u>
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 4</u> , 19 <u>86</u> , to <u>June 15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June 15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Samuel D. Loube, M.D.</u> DEGREE | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Samuel D. Loube, M.D.</u> | | | | 22e. ADDRESS <u>730 24th Street N.W. #7, Washington, D.C. 20034</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | June 18, 1986 | | Mt. Olivet Cemetery | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey | | JUN 18 1986 | | Julia Davidson-Rodell | |
| P.A. 7557 Wisconsin Avenue, Bethesda, Maryland | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | Janesville Wisconsin | | | |

TO THE SECRETARY OF AGRICULTURE
WASHINGTON, D. C.
FROM THE SECRETARY OF AGRICULTURE
WASHINGTON, D. C.
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report.]

(14) [Illegible]

00-10130

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17814

| | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|-------------------|--|--|
| 1. FOR
STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) William L. Ricketts | | | | | | 2a. DATE KNOWN OF DEATH
ESTI. MATED <input type="checkbox"/> MONTH DAY YEAR 6 19 86 | | | 2b. HOUR A | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR May 8, 1925 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 61 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 6 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
301-B Dawson Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Stone Mason | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE Maryland | | | | 12b. COUNTY Montgomery | | 12c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
301-B Dawson Ave. Rockville, Md. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Ricketts | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Carter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO.
(IF KNOWN, YEAR OR DATES) WW II | | 17. INFORMANT ADDRESS
Carl Ricketts same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) CHRONIC LIVER DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) ALCOHOLISM | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
INDEX
INDEX | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 6 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FOUND DEAD IN BED | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
301-B Dawson Ave. Rockville MONT MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle | | | | TITLE (SPECIFY) Dept | | | | DATE SIGNED 6/19/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle | | | | ADDRESS 820 W. Carroll Ave. Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 6/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION
CITY STATE Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BLOCK IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. LONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, OR REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

1

0-10276

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 1 5
REG. NO.

| | | | | | |
|--|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Lillie MAE RIGGS | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 19 86 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 27, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN E. JOHNSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma Pratt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
578-43-3161 | | 17. INFORMANT ADDRESS
Juanita Imes 18707 Jerusalem Ch. Rd.
Poolesville, MD 20837 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Coronary Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b). <u>Advanced Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c).
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1 year
6 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Peripheral Arteriosclerosis with Dry Gangrene Right Leg</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/7/86</u> to <u>6/19/86</u> , that (I) (we) last saw the deceased alive on <u>6/19/86</u> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert C. Macon | | DEGREE
M.D. | | 22c. DATE SIGNED
6/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Macon M.D. | | 22e. ADDRESS
809 Vers Mill Rd. Rockville, Md. 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Montg. MD | | 24. FUNERAL DIRECTOR
George R. Snowden Rockville, MD 20850 | | | |
| 25. DATE REC'D BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE
Julia Dendron-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter. It contains several paragraphs of text, some of which may be related to agricultural or administrative matters. Key words like "subject", "reference", and "enclosure" are faintly visible.]



00-10231

1- FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

17816

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
COL. GUSTAVE ALBERT RING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 13 1986 | | 2b. HOUR
DAY
2:55 A.M. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 14 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELAWARE | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Western Union |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
OLNEY | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3230 SPARTUM ROAD 20832 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATHAN RING | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Karoline MAIER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1941-1963 | 17. INFORMANT
ADDRESS
WILHELMINA RING, 3230 SPARTUM ROAD, OLNEY, MD | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
CEREBROVASCULAR ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **JUNE 10, 1986** to **JUNE 13, 1986**, that (I) (we) last saw the deceased alive on **JUNE 13, 1986**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.

| | | | |
|---|---------------------|--|--------------------------------------|
| 22b. SIGNATURE
<i>Gustave R. Calleja</i> | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
13 JUN 86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. A. CALLEJA, LT, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/17/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia |
|---|-------------------------------|---|--|

| | | |
|---|---|---|
| 24. DONOR OF ORGAN
STEIN HEBREW MEMORIAL FUNERAL HOME | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | 25b. REGISTRAR'S SIGNATURE
<i>Gustave R. Calleja</i> |
|---|---|---|

232 CARROLL STREET, N. W., WASHINGTON, D. C.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED
JAN 10 1900
NEW YORK



John D. [unclear]

Very respectfully,
[Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

0-09937
6

47
78
38
57
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Shirley SHINAS Robbin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 11 86
2b. HOUR
2:43 PM | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
10 10 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83
YRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U S A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(IF DEPARTMENT OF WORKING LIFE)
AGRICULTURE | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVERNMENT |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
ROCKVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
MENDEL MIDDLE SHINAS | | 15. MOTHER'S MAIDEN NAME
IDA FIRST MIDDLE LAST KRIM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.
578-32-6012 | 17. INFORMANT
ADDRESS
CHARLES M. PASCAL, 3300 SOUTH OCEAN BLVD.
PALM BEACH, FLORIDA | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC arrest

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) Severe COPD (Chronic obstructive Pulmonary Disease)

DUETO, OR AS A CONSEQUENCE OF

(c) Right cardiac stroke with new onset seizures

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: UROSEPSIS

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> 19 <u>86</u> , to <u>6-11</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6-11</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Philip Jay Schwartz MD | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6-11-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP JAY SCHWARTZ MD | 22e. ADDRESS
9715 Medical Center Drive #315 Rockville, MD 20852 | | |

| | | | |
|--|------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
6/12/1986 | 23c. NAME OF CEMETERY OR CONGREGATION
BETH SHOLOM CONGREGATION CEMETERY | 23d. LOCATION
CITY
CAPITOL HEIGHTS, PRINCE GEORGE'S |
| 24. FUNERAL DIRECTOR
NAME
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25. DATE REC'D. BY REGISTRAR
26. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

10000-0

4000 2000

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0-10140

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

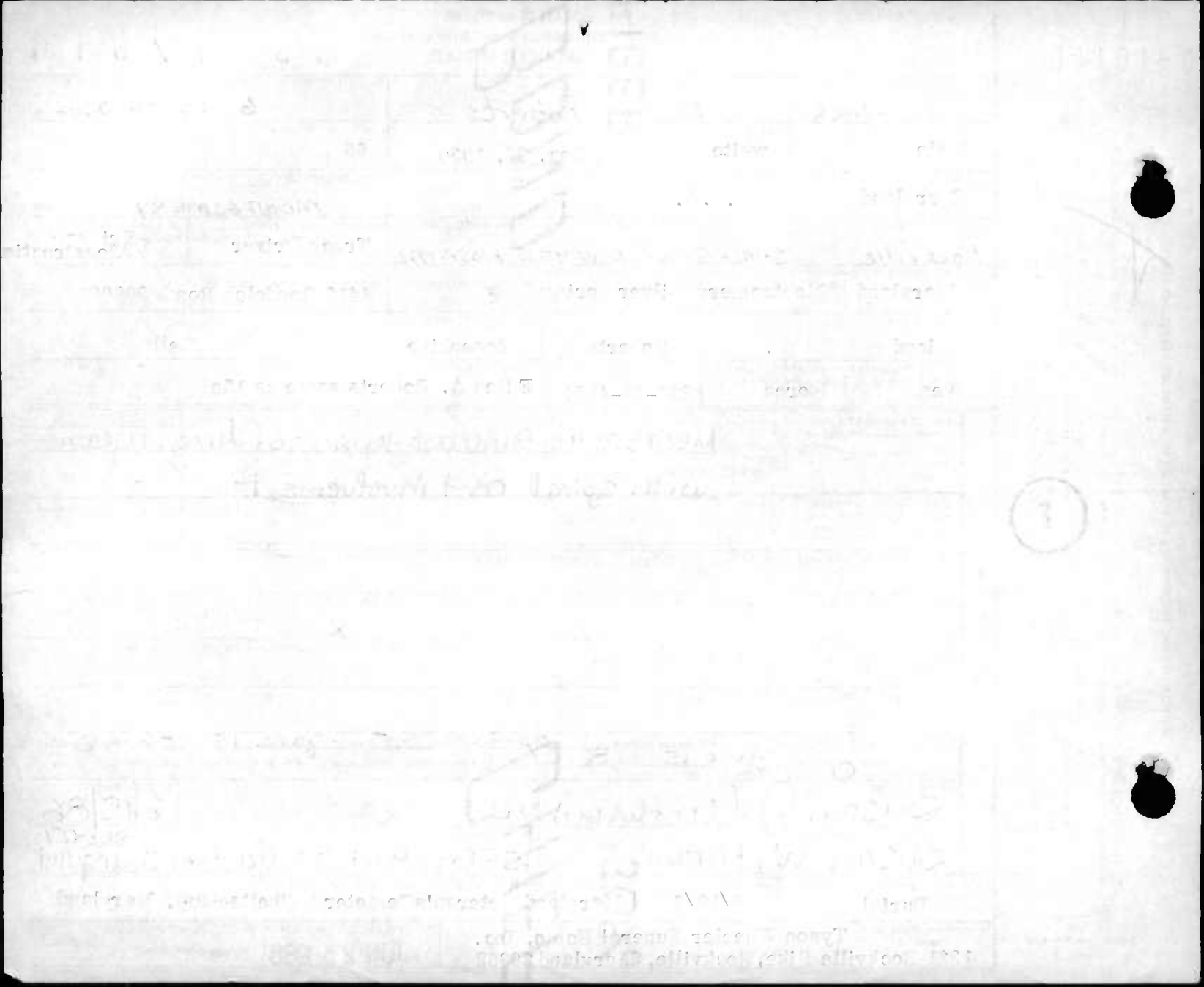
IMPORTANT: If item 21 is marked or item 18 shows any injury, another fatal event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17818

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JACK L. Roberts | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 15 86 | | | 2b. HOUR
2206 M | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 26, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Da Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Silver Spring | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4413 Randolph Road 20906 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lloyd L. Roberts | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Josephine Bell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES AND OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) Korea | | 17. INFORMANT ADDRESS
Ellen A. Roberts same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Pancoast tumor of lung. 1 year
DUE TO, OR AS A CONSEQUENCE OF
(b) with spinal cord involvement.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 85, to June 15 19 86, that (I) (we) last saw the deceased alive on June 15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Susan J. Withrow MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Susan Withrow | | | | 22e. ADDRESS
15 E Deer Park Dr. Gaithersburg Md. 20877 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
6/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veteran's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
John Dearden | | | |

BP



00-08794

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," it should show any injury, or other traumatic event, the medical examiner must be notified of one.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 1 9
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CATHERINE M. ROBINSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-2-86 | | 2b. HOUR
5 45 PM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
10 3 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired worker | | 12b. KIND OF BUSINESS OR INDUSTRY
bakery |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Rockville | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
5016 Macon Road 20852 | |
| 14. FATHER'S NAME
Thomas MIDDLE Gannon LAST | | 15. MOTHER'S MAIDEN NAME
Mary FIRST Lehy MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
137-18-9785 | | 17. INFORMANT
Gloria M. Vaughan same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Aortic Aneurysm Rupture
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from Oct. 1980 , to June 2, 1986 , that (1) we last saw the deceased on June 2, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, above, (1) we did not view the body after death.) | | | | | |
| 22b. SIGNATURE
G. Hallick | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. HALLICK | | 22e. ADDRESS
Rockville, Md. 20852
11125 Rockville Pike | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/5/86 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland 20852 | | 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | | 25b. REGISTRAR'S SIGNATURE
L. L. Anderson | |

MEDICAL CERTIFICATION

RELEASED BY ME

00-68784

RECEIVED
JAN 11 1964

90% COTTON

Office of the

United States

Department of Justice

Washington, D.C.

January 11, 1964

00-11158

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

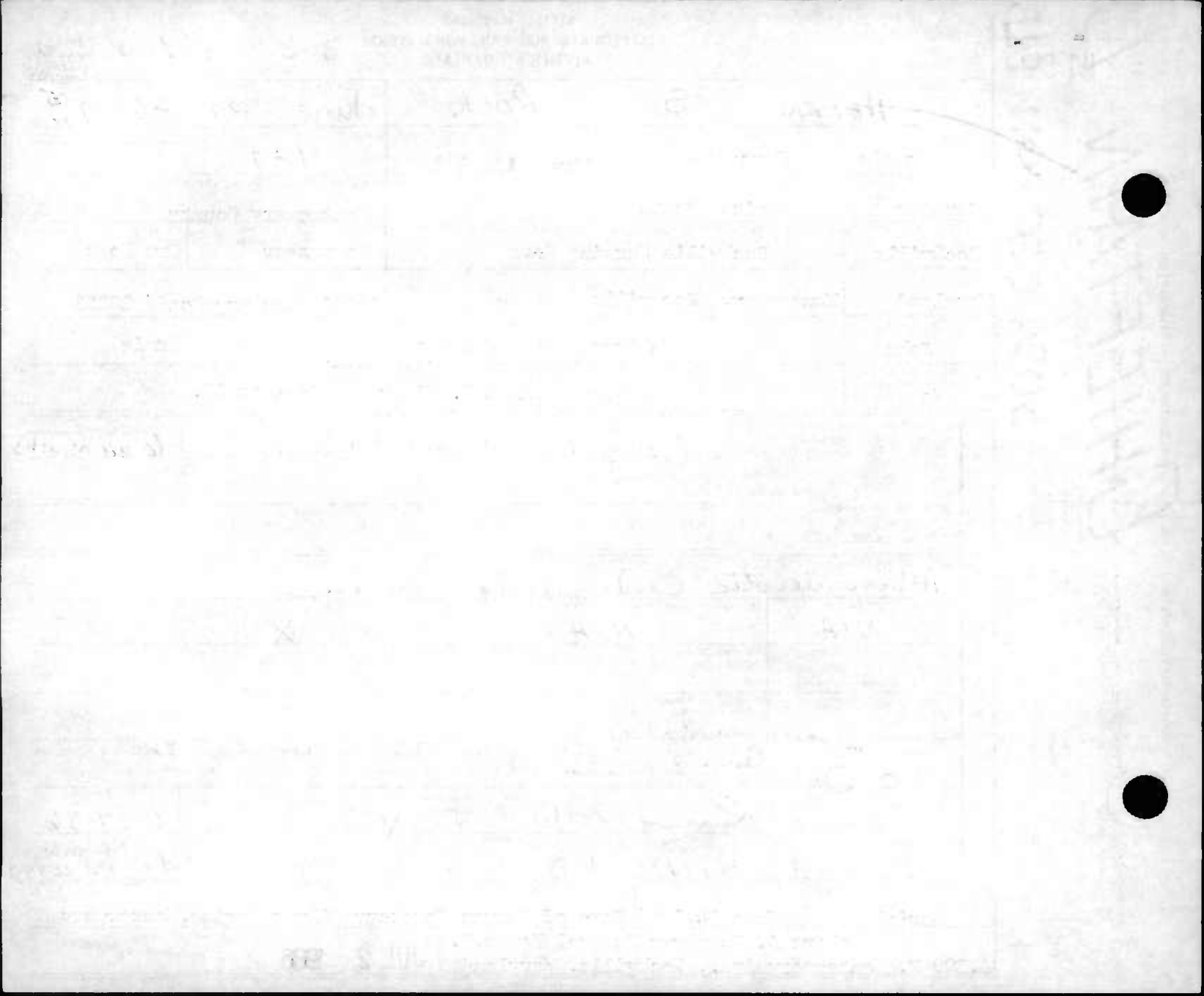
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17820
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN S. Rock | | 2a. DATE OF DEATH MONTH DAY YEAR
June 27 86 | | 2b. HOUR
9:25 M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
May 13, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
97 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Schirra | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Kathleen Emmig | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
049-05-4069 | |
| 17. INFORMANT (daughter) ADDRESS
Anne C. Viner Same as 13. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Cardiovascular Disease | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
may 19 73 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> (our medical office) | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that I (this hospital) attended the deceased from may 19 73 to June 27 19 86 , that I (we) last saw the deceased live on June 27 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | 22b. SIGNATURE
Donna Rinis MD | |
| 22c. DATE SIGNED
6-27-86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONNA RINIS MD | | 22e. ADDRESS
11510 Old Georgetown Rd. Rockville, Md. 20852 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, Montgomery MD | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | 24b. ADDRESS
Funeral Homes, P. A. 300 W. Montgomery Ave., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



7 8 2 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER THE DEATH OF THE DECEASED. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER THE DEATH OF THE DECEASED.

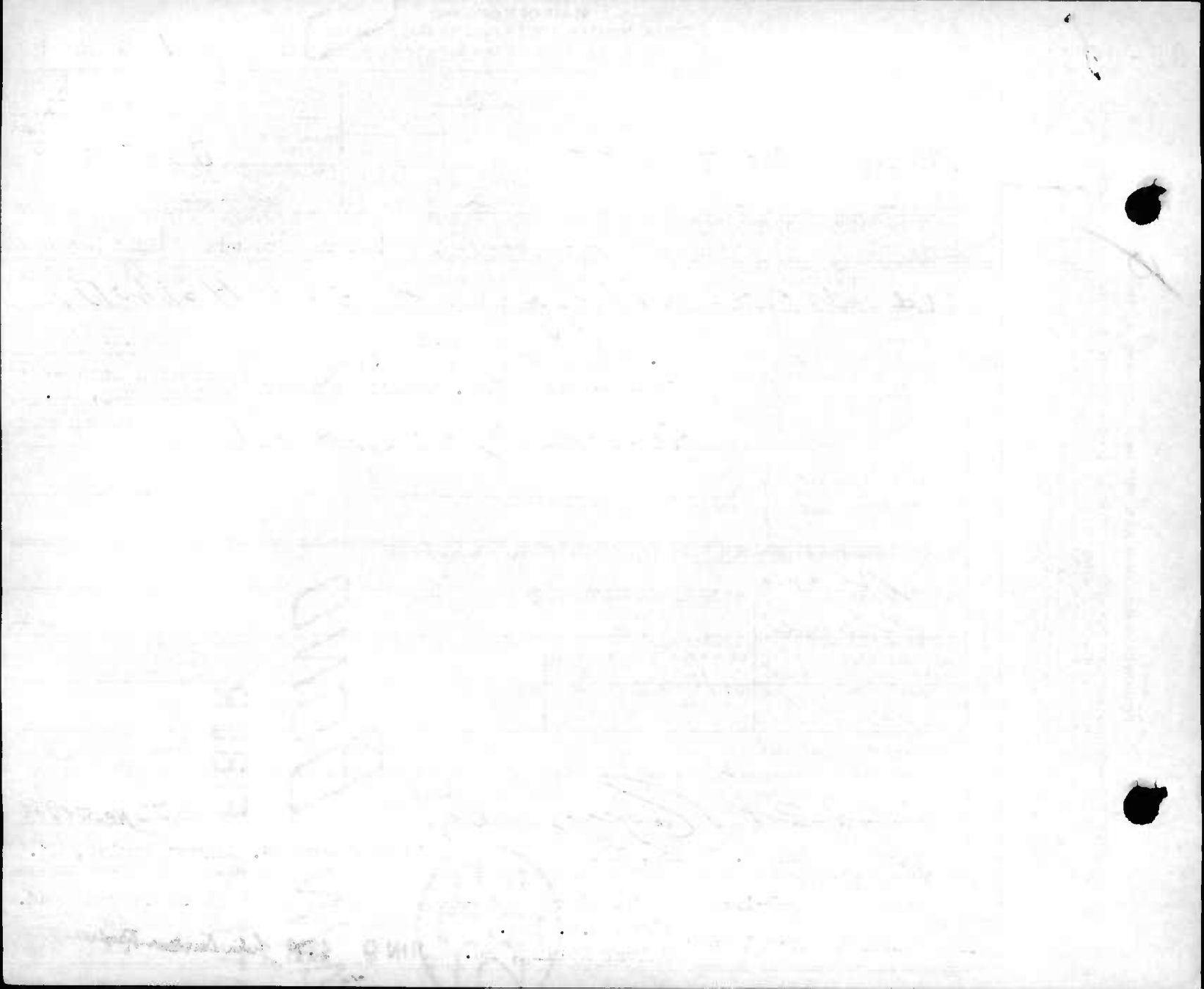
TO STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS: 201 WEST PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A) 5 ME (5)
20M 4/B2

| | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|---|--|------------------|--|---|--|-------|--|-----------------------------------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 26. HOUR | |
| Ivan | | E. | | Rodeffer | | | | 20. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 26. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | | W | | August 01 1984 | | 24 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | | 7c. DATE PRONOUNCED DEAD | | 26. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Virginia | | | | USA | | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Olney | | | | Montgomery General Hospital | | | | | | | | Retired Produce | | | | Self Employed | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Md | | | | Montgomery | | | | Bryantown | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 621 Hobbs Dr 20904 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT (son) | | | |
| Henry | | | | Laura | | | | N/A | | | | 579-22-2803 | | | | Rev. Robert Rodeffer | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| (b) _____ | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| (c) _____ | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| None | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | | | |
| None | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | | | | | STREET | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | MEDICAL EXAMINER | | | | DATE SIGNED | | | | | | | |
| John S. Rogers, DME | | | | M.D. Dep. | | | | | | | | June 5 1984 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| John S. Rogers, DME | | | | 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | | | 6-7-1986 | | | | Fort Lincoln Cemetery | | | | Brentwood Prince Georges Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Hines/Rinaldi Funeral Home | | | | JUN 9 1986 | | | | Julia Rinaldi | | | | | | | | | | | |
| 11800 N.H. Ave., Silver Spring, Md. | | | | | | | | | | | | | | | | | | | |



00-08914

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 2 2
REG. NO.

| | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|-----------------------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM H. ROHRMAN | | | 2a. DATE OF DEATH
MONTH 6 DAY 3 YEAR 1986 | | | 2b. HOUR
830 P M | | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 12 DAY 08 YEAR 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARRIAGE HILL NURSING CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dept. of Agriculture US Gov't. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8101 Springvale Road 20910 | | |
| 14. FATHER'S NAME
FIRST Fredrick MIDDLE W LAST Rohrman | | | | 15. MOTHER'S MAIDEN NAME
FIRST Caroline MIDDLE Frey LAST Frey | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-46-5971 | | 17. INFORMANT Sister-in-Law ADDRESS Silver Spring, Maryland
Elsie E. Loehl 9028 Fairview Road 20910 | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardio-respiratory Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis | | 25 years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Insufficiency | | 20 years | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 46 , to June 3 , 19 86 , that (I) (we) last saw the deceased alive on June 3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John E. Everett M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
6/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN E. EVERETT | | | | 22e. ADDRESS
9400 CONN. AVE., KENSINGTON, MD. | | | |

| | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN Washington, D.C. COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins, Jr. ADDRESS
500 University Blvd. Wst Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson Anderson | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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00-09822

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 2 3
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Roscher | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 13 1986 | | 2b. HOUR
9:20 am |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 03 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10108 Gladstone Street | | 12a. OCCUPATION (TYPE OF WORKING LIFE)
Electronics Technician | 12b. KIND OF BUSINESS OR INDUSTRY
Surface Naval Weapons | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
10108 Gladstone Street 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Roscher | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
ADDRESS
John Roscher 412 Park Road Rockville, Md. 20850 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SHOCK

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 DAY

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

METASTATIC CANCER

8 MOS

DUE TO, OR AS A CONSEQUENCE OF

(c)

CANCER OF HEART NEUR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1985, to 6/13, 1986, that (I) (we) last saw the deceased alive on 6/5/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Stanley A. Schwartz | DEGREE
M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6/13/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stanley A. Schwartz, M.D. | | 22e. ADDRESS
#211
2101 Medical Park Drive Silver Spring, Md. | |

| | | | |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 16, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Prince George's Md. |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | |
| 500 University Blvd. West Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE
James Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

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00-10127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____
DHMM - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 86 17824 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
OSCAR E. ROSS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
6-19-86 1:35 AM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 9, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Wilson Health Care Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Banker | | 12b. KIND OF BUSINESS OR INDUSTRY
Banking | |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
407 Russell Ave., 20877 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Oscar E. Ross, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma Lewis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
217 14 5536 | | 17. INFORMANT ADDRESS
Christopher Rupp, Germantown, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic Obstructive Lung Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>10 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease, Diabetes Mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-21-</u> 19 <u>80</u> to <u>June 19</u> 19 <u>86</u> , that (I) (we) lost above <u>(I) (we) (did) (did not) view the body after death.</u> | | | | | | | | | |
| 22b. SIGNATURE <u>James R. Moore Jr.</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>6-19-86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. | | 22e. ADDRESS
207 Brookes Ave Gaithersburg md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Pikesville, MD | | | |
| 24. FUNERAL DIRECTOR NAME
Henry W. Jenkins & Sons Co. | | 24b. ADDRESS
4905 York Road Balto., MD 21212 | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 2 5

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FANNIE J ROVIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 2 86 | | 2b. HOUR
7:10 _M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
2 13 09 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | |
| 10. CITY OR TOWN OF DEATH
POTOMAC | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6 ELDWICK COURT CT (MONTGOMERY CO.) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 13a. STATE
MICHIGAN | | 13b. COUNTY
SOUTHFIELD | 13c. CITY OR TOWN
SOUTHFIELD | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
29251 POINTE O WOODS PLACE 99999 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BEN JACOB GOOZE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SHAYNDL FEINSTEIN | | ADDRESS
7243 Mohansic | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
369-48-3992 A | | 17. INFORMANT
7243 Mohansic
Marshall Greenspan Birmingham, Michigan | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>METASTATIC LIVER CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bruce Kressel | | | | 22c. DATE SIGNED
6/2/1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE KRESSEL, M. D. | | | | 22e. ADDRESS
5480 Wisconsin Avenue, Chevy Chase, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/4/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Machpelah Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Berkley, Michigan | | |
| 23e. DIRECTOR'S NAME
DONALD M. STEIN | | | 23f. DATE REC'D BY REGISTRAR
JUN 05 1986 | | |
| 23g. DIRECTOR'S ADDRESS
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | 23h. REGISTRAR'S SIGNATURE
John Davidson | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.25a. DATE REC'D BY REGISTRAR
JUN 05 1986

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 7 8 2 6

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|--|--|---|--|---|--|-------------------------|--|---------------------|--|-------------------------|--|--------------------------------------|--|----------------|--|------------------|--|--------------------------|--|----------|--|-----|--|------|--|----------|--|
| 1- STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| | | RICHARD | | | | | | RUSCIGNO | | 6 | | 17 | | 19 | | 86 | | 06 | | M | | | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | MONTH | | DAY | | YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | Caucasian | | 1 | | 31 | | 29 | | 57 | | YRS. | | | | | | 6 | | 17 | | 19 | | 86 | | 06 | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | |
| New York | | United States | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | MONTGOMERY | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS | | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | SUBURBAN HOSPITAL | | Postal Clerk | | U.S. Postal Service | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| N.Y. | | Nassau | | FLORAL PARK | | YES | | NO | | 4 | | QUEST NUT AVE | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jackamo | | Ruscigno | | Mary | | Guido | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | Korean | | 068-22-1356 | | Edna H. Ruscigno (Wife) | | 4 Chestnut Avenue | | Floral Park, New York | | 11001 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | IMMEDIATE CAUSE (a) | | MYOCARDIAL INFARCTION | | ACUTE | | | | | | | | | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | INDEX | | | | | | | | | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | DIABETES MELLITUS | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | |
| WHILE AT WORK | | NOT WHILE AT WORK | | 5:30 P.M. | | 6 | | 17 | | 86 | | COLLAPSED WHILE DRIVING CAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | |
| WHILE AT WORK | | NOT WHILE AT WORK | | STREET | | WISCONSIN AVE | | BETHESDA | | MONTGOMERY | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy | | Inspection | | Inquiry | | and in my opinion | | | | | | | | | | | | | | | | | | | |
| Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | |
| FRANCIS C MAYLE | | M.D. DEPT | | 6/17/86 | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | | | | | | | | | |
| Cremation | | June 18, 1986 | | Metropolitan Crematory | | Alexandria, Virginia | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes P.A. | | JUN 19 1986 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7557 Wisconsin Avenue Bethesda, Maryland 20814 | | | | | | | | | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DMMH-17
(VR A15 ME (1))

No. 254, 132,

00-10828

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 2 7
REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>GERTRUDE W. RUSSELL</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>06 24 86</u> | | 2b. HOUR
<u>6 28</u> P.M. | |
| 1. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>June 5, 1906</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Wisconsin</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>80</u> YRS. | |
| 11. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Teacher</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Public Schools</u> | | | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Bethesda</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>William C. Walz</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Georgia Smith</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>213-38-3395</u> | | 17. INFORMANT (Husband) ADDRESS
<u>Kenneth M. Russell 4512 Avamere Street Bethesda, MD 20814</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>myocardial rupture</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 min</u>
<u>30 min</u>
<u>9 hrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-24</u> , 19 <u>86</u> , to <u>6-24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Thomas G. Sundersen, MD</u> | | | | 22c. DATE SIGNED
<u>6-24-86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>THOMAS G. SUNDERSEN, MD</u> | | | | 22e. ADDRESS
<u>11125 ROCKVILLE PIKE, ROCKVILLE, Md. 20852</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>June 25, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Metropolitan Crematory</u> | |
| 23d. LOCATION
<u>Alexandria</u> | | 23e. COUNTY
<u>Virginia</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>JUN 30 1986</u> | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

010054



WILLIAM

NOTICE

1-20-1900

Released by Dr. Mayle 6/86

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John F. Russo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 27, 1986 | | | 2b. HOUR
3:40a M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 23, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
301 Russell Avenue. 20877 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank P. Russo | | | 15. MOTHER'S MAIDEN NAME
MIDDLE
Not Available Cacciata | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
069-01-8572 | | 17. INFORMANT
Robert V. Russo 1961T Sparr Spring Road
Gaithersburg, Maryland 20879 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of the colon</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4/86</u>
<u>9/84</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6/27</u> 19 <u>86</u> to <u>6/27/86</u> 19____, that (1) (we) last saw the deceased alive on <u>N/A</u> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Cheryl Winchell MD</u> | | | | DEGREE <u>(for Dr. Melinda Wolf)</u>
ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
June 27, 1986 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Cheryl E. Winchell, M.D. | | | | 22e. ADDRESS
Gaithersburg, Maryland
19241 Montgomery Village Avenue | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
July 1, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Denis Cemetery | | 23d. LOCATION
E. Fishkill Dutchess New York | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES
PA, 300 West Montg. Ave. Rockville, MD | | | | 25. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | |

BP

00-11161

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

1- FOR
STATE
REGISTRAR

James H. Ryan

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17829

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
JAMES H. RYAN | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-29-86 | | 2b. HOUR
9:35 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 19, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Beth. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Jeweler | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Beth | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
6148 - 31st. St. NW | | 13f. STREET ADDRESS / ZIP CODE
20814 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Patrick Henry Ryan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ollie White | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I | | 17. INFORMANT
Catherine B. Ryan Same as Item # 13 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATO-RENAL SYNDROME</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHOLANGITIS</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 WEEK</u>
<u>2 WEEKS</u>
<u>3 WEEKS</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>CONGESTIVE HEART FAILURE</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-29-86</u> to <u>6-29-86</u> that (I) (we) last saw the deceased alive on <u>6-29-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Herbert L. Tanenbaum</u>
(MEDICAL PHYSICIAN'S NAME (TYPE OR PRINT)) | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/27/86 | |
| 22d. ADDRESS
<u>5480 Wisconsin Ave Chevy Chase, MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
7/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arl. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arl., VA 20815 | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 WI Ave. NW Wash., DC 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Galia Davidson</u> | |

10-1161

James H. Ryan

NA 25:3

| | | | | | |
|---------------------|------------------|----------------|---|-----------------------------------|---------------|
| White | White | Sept. 19, 1928 | x | Montgomery | Self-employed |
| Illinois | U.S.A. | | | | |
| Heck | Goodman Hospital | Jeweler | | | |
| Mr. Gies - 21st St. | Beth | x | | Gies - 21st St. NW | |
| Patrick | Henry | Ellie | | White | |
| Yes | WM I | 379-01-2035 | | Catherine - (own name as item 13) | |

20% COTTON FIBER

Burial
 7/5/86
 Joseph Jeweler's Sons, Inc.
 2130 W Ave. NW Wash., DC 20018
 Atl., Va

00-11044

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17830

REG. NO.

| | | | | | | |
|--|--|--|---|---|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE JANE LAST RYAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
06-23-86 | | 2b. HOUR
430AM | |
| 3. SEX
FEMALE | | 4. RACE
CAU. | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 01 25 | | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO MD | | |
| 12a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE MARYLAND 12b. COUNTY MONT. 12c. CITY OR TOWN BETHESDA | | 12d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12e. STREET ADDRESS / ZIP CODE
9231 SINGLETON DRIVE 20811 | | |
| 13. FATHER'S NAME
FIRST JOHN MIDDLE LOUIS LAST HARDING | | 14. MOTHER'S MAIDEN NAME
FIRST JULIA MIDDLE O'BRIEN LAST | | 15. ADDRESS
SAME AS DECEASED | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-22-6335 | | 17. INFORMANT
HUSBAND - DONALD RYAN - #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OVERWHELMING SEPTICEMIA 2 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION 4 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE SCLEROSIS 30 YEARS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on MAY 22 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If two (did) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
[Signature]
THE PHYSICIAN'S NAME (TYPE OR PRINT) | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
June 23, 1986 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6-25-86 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEM | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MD | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | | |
| 24. FUNERAL DIRECTOR
NAME
[Signature] - DEVOL FUNERAL HOME
WASHINGTON, D.C. | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, or if there is any injury, or other traumatic event, the medical examiner must be notified.

BP

JUN 30 1986

John Bonham-Rudner



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]

0-10138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit document, and page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Baby Boy | | First Baby Middle Boy Last "A" SALASSI | | 20. DATE OF DEATH
Month June Day 15 Year 1986 | | 2b. HOUR
11:45 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 15, 1986 | | 6. AGE (In years last birthday)
YRS. 35 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
3503 Pear Tree Ct. #42 | |
| 14. FATHER'S NAME
First Michael Middle E. Last Salassi | | 15. MOTHER'S MAIDEN NAME
First Brenda Middle Sylvest Last Sylvest | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Address Michael E. Salassi same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURITY 22 2/7 WEEKS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ABRUPT PLACENTA
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 86 , to 6/15 , 19 86 , that (I) (we) lost the deceased alive on 6/15/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lewis Townsend | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/16/86 | |
| 22d. PHYSICIAN'S NAME (Type)
Lewis Townsend, M.D. | | 22e. ADDRESS
10215 Fernwood Rd. Bethesda, Md. 20817 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
6/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Sutland, Maryland | |
| 24. FUNERAL DIRECTOR
Pyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | 25a. REC'D BY REGISTRAR
DATE JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Jana Davidson | |

MEDICAL CERTIFICATION

3

WM 20817

basly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-10139

1. FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 3 2

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Baby Boy | | 2a. DATE OF DEATH
June 15, 1986 | | 2b. HOUR
11:45 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
June 15, 1986 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS MONTHS DAYS HOURS MIN
32 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3503 Pear Tree Ct. #42 20906 | |
| 14. FATHER'S NAME
FIRST Michael MIDDLE E. LAST Salassi | | 15. MOTHER'S MAIDEN NAME
FIRST Brenda MIDDLE Sylvest LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
Michael E. Salassi same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURITY 22 2/7 WEEKS.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
(b) ABORTIO PLACENTA.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/15, 1986, to 6/15, 1986, that (I) (we) lost saw the deceased alive on 6/15/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
L. M. E. M. | | DEGREE | | 22c. DATE SIGNED
6/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis Townsend, MD. | | 22e. ADDRESS
10215 Fernwood Rd. Bethesda, Md. 20817 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
6/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | |
| 23d. LOCATION
Sutland, Maryland | | STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE | |

2010-10



J-10377

TO HOSPITALS OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17833
REG. NO.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MARY MIDDLE G. LAST SALMEN | | 6 21 86 | | 7 15 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| F | White | 3 29 06 | 80 YRS. | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| COLORADO | U.S.A. | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | FERNWOOD NURSING HOME | HOUSEWIFE | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| NEW HAMPSHIRE | HILLSBORO | WEARE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | RFD 03281 9999 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| FIRST ROAY MIDDLE A. LAST GOODALE | FIRST FLORA MIDDLE LAST ADAMS | NO | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 001-30-0421 | CARLETON S. COON, JR, SON, | 3520 EDMUNDS ST., N.W., WASH., DC | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| WIA | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 4/22 19 86 to 6/21 19 86, that (we) last saw the deceased alive on 6/21 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| CARE J. MARGOLIS | M.D. | | | 6/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| CARE J. MARGOLIS | 11404 OLD GEORGETOWN RD, ROCKVILLE MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| CREMATION | 6/22/86 | METROPOLITAN CREMATORY | ALEXANDRIA, VIRGINIA | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | | J. H. HENDERSON | |

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00-09140

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 2a Per. # H.6/24/86jab

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 1/8 35

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charlotte H. Saylor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 9, 1986 | | | 2b. HOUR
11:05^{am} | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 26, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Congress | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15521 Prince Frederick Way Zip: 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Nance | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Stagg | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
223-16-8361 | | | 17. INFORMANT
ADDRESS
Robert L. Saylor, Jr.
Husband, Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory + Cardiac Arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Ventilatory Failure & Acute Exacerbation 1 week | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Obstructive Pulmonary Disease years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Rt. heart failure - Cushingoid - Chronic Steroid therapy | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from December 19 83 to June 9, 19 86 , that (I) XXXX saw the deceased alive on June 9, 19 86 , and that in (my) XXXX opinion death occurred on the date and hour and from the causes stated above, (I) XXXX did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Oliver J. Lawless M.D. DEGREE MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6.9.86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Lawless M.D. | | | | | | 22e. ADDRESS
Heisner World Medical Center Silver Spring MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
June 10, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
ADDRESS
P.A., 7557 Wisconsin Ave., Bethesda, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

2000

2000

2000

2000

0-09137

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17836

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELSIE B SCHMEDEGAARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-6-86 | | 2b. HOUR
5 P.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
4 12 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Resident Mgr. Apartment Complex | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Prince Geo. | 13c. CITY OR TOWN
Bowie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry O White | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kate F Earle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | 16b. SOCIAL SECURITY NO.
213-40-6494 | 17. INFORMANT
Son ADDRESS Annapolis, Maryland
Robert Blackwood 317 Eatons Landing Dr. 21401 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

POST OPERATIVE COMPLICATION
SEVERE AORTIC STENOSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|---|---|--|--|
| 19a. DATE OF OPERATION
6/5/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
SEVERE AORTIC STENOSIS | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/5/86 , 19 86 , to 6/6/86 , 19 86 , that (I) (we) last saw the deceased alive on 6/5/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Arnon S. Rao | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6/6/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arnon S. Rao | 22e. ADDRESS
9131 PISCATAWAY RD. CLINTON MD 20735 | | |

| | | | |
|---|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
June 10, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd. Silver Spring, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodale |

76180-0

2009 COLLOID LIBER

WINTER DND



60-11797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17837

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Hulbert (Thomas) Schrider | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4/28/86 | | 2b. HOUR
02:10 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 8 1910 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adv. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plummer | | 12b. KIND OF BUSINESS OR INDUSTRY
Plumbing |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James E. Schrider | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa L. Macauley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-05-7621 | | 17. INFORMANT
ADDRESS
34 Dalamar St.
Mary VanHorn Schrider Gaithersburg, Md. 20877 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER (small cell, pulmonary)
DUE TO, OR AS A CONSEQUENCE OF
(b) congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
10 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CAD, HBP | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DENNIS FREEMAN | | 22e. ADDRESS
1315 East Deer Park, Gaithersburg | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
July 1, '86 | 23c. NAME OF CEMETERY OR CREMATORY
Resthaven Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick Md. | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | 25. DATE REC'D. BY REGISTRAR
JUL 02 1988 | | 26. REGISTRAR'S SIGNATURE
Julia Sandison-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

05-41710

Subject (Thomas) Schmidt

White 1910 1910

1910 1910 1910

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 3 8
REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | June 14, 1986 | | 7:00a M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| Female | | White | | Oct. 16, 1910 | | 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Austria | | U.S.A. | | | | Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | 14000 Broomall Lane | | Homemaker | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 14000 Broomall Lane / 20906 | | | |
| Kasper - Tesar | | Matilda - Kusi | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | None | | 115-32-3880 | | Germaine Klang (Daughter) Same as # 13. | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) INANITION | | | | | | | WEEKS |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA | | | | | | | WEEKS |
| DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OVARY | | | | | | | UNKNOWN |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 5-7-86 | | CARCINOMA OVARY | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-20-86, 19, to 6-14-86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Dr. Leonard Deitz, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | June 14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Dr. Leonard Deitz, M.D. | | | | 1900 Forest Glen Rd. Silver Spring, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | JUNE 16, 1986 | | New St. Raymond's Cemetery | | Bronx, New York | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | | | JUN 17 1986 | | Julia Davidson-Rodell | |
| Chambers Funeral Home Silver Spring, Maryland | | | | | | | |

0-10585-

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|--------------------------------------|--|---|--|
| 1. FOR REGISTERAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>ROTH</u> <u>E.</u> <u>Seese</u> | | | | | 2a. DATE OF DEATH
MONTH <u>6</u> DAY <u>19</u> YEAR <u>86</u> 2b. HOUR <u>2:27</u> AM | | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH <u>Nov.</u> DAY <u>16</u> YEAR <u>1902</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>83</u> YRS | | 7. IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Chevy Chase</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Bethesda Retirement Center</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Clerk</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Trade Association</u> | | |
| 13a. STATE
<u>Maryland</u> | | | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Bethesda</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>Martin</u> MIDDLE <u>Luther</u> LAST <u>Armentrout</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mattie</u> MIDDLE <u>Huffman</u> LAST <u>Huffman</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>577-42-9411</u> | | 17. INFORMANT
ADDRESS <u>3555 Mallory Court</u>
<u>Nelson M. Seese Falls Church, VA</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronehropneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myotrophic Latrod Scorpionis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>6 mos</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR <u></u> A.M. <u></u> MONTH <u></u> DAY <u></u> YEAR <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u> | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 56</u> to <u>June 19 86</u> , that (we) last saw the deceased alive on <u>6/11/86</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Marvin Wadler</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>6/19/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MARVIN WADLER</u> | | 22e. ADDRESS
<u>8218 Wisc. Av. Beth. Md 20814</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>June 23, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION
CITY OR TOWN <u>Suitland</u> COUNTY <u>Maryland</u> STATE <u></u> | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Robert A. Pumphrey</u> | | ADDRESS <u>Funeral Homes</u> | | 25a. DATE REC'D BY REGISTRAR
<u>JUN 26 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. A. Davidson-Randall</u> | | | | |

BP

2
00-107181- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17840
REG. NO.

| | | | | | | |
|---|--|---|---|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA SEIDMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/24/86 | | 2b. HOUR
MIN.
7:18 M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 15 00 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. AGE (IN YEARS LAST BIRTHDAY)
85 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HEBREW HOME OF GREATER WASHINGTON | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK ALTER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA (UNKNOWN) | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
052-24-8337 | | 17. INFORMANT
ADDRESS
ABRAHAM SEIDMAN, SON, 32 WEST 20TH ST., NEW YORK, NY 10011 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GASTRIC ULCER
DUE TO, OR AS A CONSEQUENCE OF (b) POLYMYALGIA RHEUMATICA
DUE TO, OR AS A CONSEQUENCE OF (c) SPINAL STENOSIS, DEPRESSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18/86 to 6/24/86 , that (I) (we) last saw the deceased alive on 6/24/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Steven Lipson | | DEGREE
MD | | 22c. DATE SIGNED
6/24/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | 22e. ADDRESS
6121 MONTROSE RD, ROCKVILLE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH DAVID CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELMONT, NEW YORK | | 24. FUNERAL DIRECTOR
NAME ADDRESS
GRAMERCY CHAPELS, INC.
152 2ND AVE., NEW YORK, NY 10003 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 27 1986 | | 25b. REGISTRAR'S SIGNATURE
Juan Davidson-Gonzalez | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

EXHIBIT

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00-10381

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 3 4 1
REG. NO.

| | | | | | | | |
|---|--|---|---|---|------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
IDA SERLICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 21 86 | | 2b. HOUR
7:45 P.M. | | |
| 3. SEX
F | | 4. RACE
W I | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 14 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
5508 Surrey Street 20815 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Levine | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sara Reve Tucker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
013-36-647 | | 17. INFORMANT
Edna Kreutz | | 17. ADDRESS
5508 Surrey St Chevy Chase | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19y | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic Subdural | | | | | | | |
| 19a. DATE OF OPERATION
6/13 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AS | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6/21 86 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/13 to 6/21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond Bass | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6-21-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | 22e. ADDRESS
3941 Ferriera Wheaton, Md 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Kodimoh Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Springfield, Mass. | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Wardson Gendall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17842 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Charles ROBERT Settle | | | | | | | | | | 2a DATE KNOWN OF DEATH MATED June 21 1986 | |
| 3 SEX M 4 RACE W 5 DATE OF BIRTH Dec 17 37 48 6 AGE (IN YEARS) 48 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 7c DATE PRONOUNCED DEAD June 21 1986 | |
| 7d BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER 12b KIND OF BUSINESS OR INDUSTRY PLUMBING | | | | | | | | | | | |
| 13a STATE MD 13b CITY OR TOWN Silver Spring 13c INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 13d STREET ADDRESS 2607 Blue Ridge Ave | | | | | | | | | | | |
| 14 FATHER'S NAME CHARLES ROBERT SETTLE SR 15 MOTHER'S MAIDEN NAME RUTH MAY HIFFENDAFFER | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b SOCIAL SECURITY NO. 215-34-3958 17 INFORMANT THERESA M. WAGNER ADDRESS 2607 BLUERIDGE AVE SILVER SPRING MD. | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial Dis. Yr.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None | | | | | | | | | | | |
| 19a DATE OF OPERATION None 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED June 21 1986 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 6/24/1986 23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEM. 23d LOCATION OR TOWN ROCKVILLE COUNTY MONTG MD | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME Takoma Funeral Home ADDRESS 54 CARROLL ST, N.W. WASHINGTON, D.C. 20012 25a DATE ISSUED BY REGISTRAR JUN 24 1986 25b REGISTRAR'S SIGNATURE John S. Rogers | | | | | | | | | | | |

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(VR A15 ME (5))

ROBERT [unclear]

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U.S.A.

MARYLAND

NUMBER REMAINING

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CHARLES ROBERT SETTLE, JR. WITH MAY 1952 AFTER

1952 BUREAU OF

1952 BUREAU OF

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ROCKVILLE, MARYLAND
1952 BUREAU OF
1952 BUREAU OF
1952 BUREAU OF

00-08896

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17843
REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Helen Winters Seubold</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>June 4, 1986</i> | | 2b. HOUR
<i>5:34 P</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Aug. 29, 1921</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
<i>64</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Kansas</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>George A. Winters</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Helen Grace Stone</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES)
<i>No</i> | | | |
| 16b. SOCIAL SECURITY NO.
<i>506-18-7540</i> | | 17. INFORMANT ADDRESS
<i>Frank H. Seubold, same as #13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive pulmonary disease yrs</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Immediate</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Intermittent cardiovascular disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4 June 1986</i> to <i>4 June 1986</i> that (I) (we) last saw the deceased alive on <i>4 June 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Horace Bernton</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5 June '86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Horace Bernton, M.D.</i> | | 22e. ADDRESS
<i>4743 Bradley Blvd. Chevy Chase, Maryland 20815</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPS 100)
<i>Burial</i> | | 23b. DATE
<i>June 9, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Park Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Claremont, California</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
<i>Robert A. Pumphrey Funeral Homes 300 West Montgomery Ave. Rockville, MD PA</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JUN 9 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | |

TO: Mr. J. H. ...
FROM: Mr. ...

SUBJECT: ...



...

...

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17844
REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | FIRST MIDDLE LAST
Albert Shaffer | | MONTH DAY YEAR
6/7/86 | | 2b HOUR
2:13 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/6/1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
DRY CLEANING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MARYLAND MONTGOMERY SILVER SPRING | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
1401 BLAIR MILL ROAD 20910 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEIB SHAFER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
LEAH BROKOW | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
223-09-4009 | |
| | | 17. INFORMANT
ADDRESS
LENORA S. RALPH, 920 MALTA LANE
SILVER SPRING, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial ischemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>myocardial infarct</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>coronary Arteriosclerosis</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<u>coronary Arteriosclerosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 22, 1986</u> to <u>June 2, 1986</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Edward J. Richards</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-7-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. EDWARD J. RICHARDS, M. D. | | 22e. ADDRESS
10301 GEORGIA AVENUE
SILVER SPRING, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
6/9/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN | | 23d. LOCATION
FALLS CHURCH, VIRGINIA | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 12 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Gina Davidson-Rodriguez</u> | |

10-00000

(A)

00-08586

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove corroborating Pages 1 and 2 and file within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 8 4 5

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William M. Sheppard | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 3, 1986 | | | 2b. HOUR
12:25pm | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 10, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY MONT. 13c. CITY OR TOWN GAITHERSBURG 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 5024 RIGGS ROAD 20879 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALEXANDER SHEPPARD | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSALIE VAUGHN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WW II 579-16-9329 | | 17. INFORMANT ADDRESS
OLA E. SHEPPARD SAME AS #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Septic SHOCK
DUE TO, OR AS A CONSEQUENCE OF (c) Septic SHOCK with PNEUMONIA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 HR.
1 1/2 HR.
24 HR. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Acute Renal Failure Requiring Dialysis; Obstructive Lung Dis. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5-14-86 , 19, to 6-3-86 , 19, that (1) (we) lost saw the deceased alive on 6-2-86 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frank Mayo | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6-3-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank Mayo, M.D. | | | | 22e. ADDRESS
16220 Frederick Rd. #213 Gaithersburg, Md. 20877 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JUNE 5, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
LAYTONSVILLE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAYTONSVILLE MONT. MD. | | | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 5 1986 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

BP

30200-00

NOV 27 1964



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00-10445

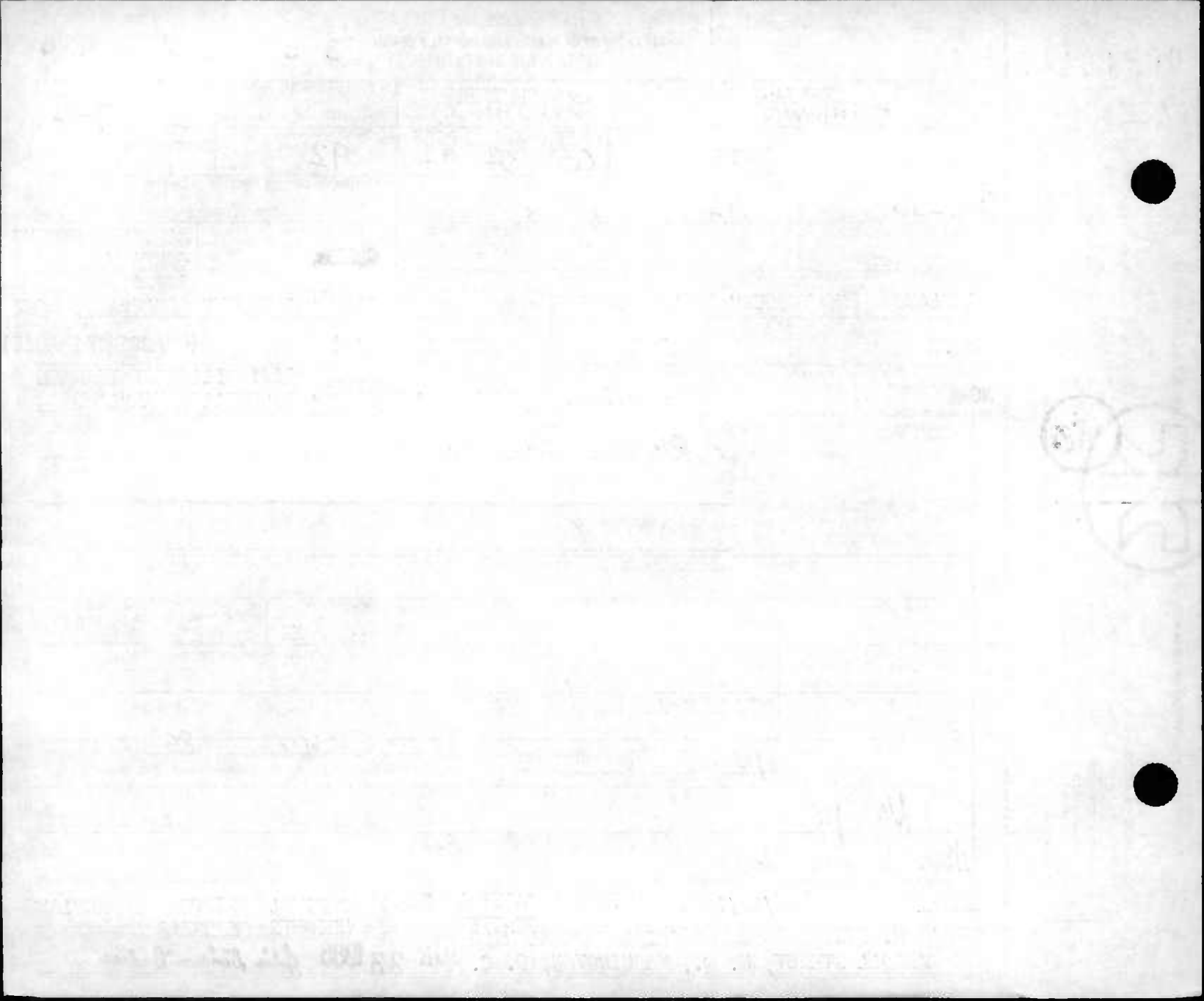
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic or medical condition, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 86 17846 | |
|--|--|--|--|---|--|--|--|--|--|-------------------------------|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIR BENJAMIN | | MIDDLE BENJAMIN | | LAST SHNIDER | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| | | | | | | | | June 17, 1986 | | 7:51 AM | |
| 3 SEX | | 4 RACE | | 5 BIRTH DATE | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS. HOURS MIN. | |
| Male | | WHITE | | MARCH 4 1894
03 04 94 | | 92 | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| POLAND | | USA | | | | Montgomery County MD | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) | | 12b USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) | | | | | |
| Silver Spring | | Bel Pre Nursing Home | | OWNER | | MINIMUM SIDDING COMPANY | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE | | | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | | | 20902 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | |
| USHER | | SHNIDER | | | | 578-38-0700A | | IRVING M. SHNIDER, 7281 MILLCREST TERRACE, ROCKVILLE, MARYLAND | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | ASPIRATION PNEUMONIA | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from above, (If we) (did) did not view the body after death. | | 19 6/17 1986 | | 22b SIGNATURE DEGREE | | 22c DATE SIGNED | | | | | |
| | | | | Mark H. Eig, M.D. | | June 17, 1986 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | | | |
| BURIAL | | 6/19/1986 | | NATIONAL CAPITOL HEBREW CEMETERY | | CAPITOL PRINCE HEIGHTS, GEORGE'S MARYLAND | | | | | |
| 24 DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | JUN 23 1986 | | Julia Davidson-Randall | | | | | | | |

BP



00-12063

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 4 1
REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN - SHREVE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 28 83 | | | 2b. HOUR
1:15 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 04 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | |
|--------------------------|--|-----------------------------|--|--------------------------------------|--|--|--|--|--|
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5721 Grosvenor Lane 20814 | |
|--------------------------|--|-----------------------------|--|--------------------------------------|--|--|--|--|--|

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|--|--|--|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
214-34-2849 | |
| 17. INFORMANT
Roger Liller | | ADDRESS
Sandy Spring Ln. Thurmont, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **obstructive jaundice probably cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Carcinoma of Colon, colicatory**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**6/11/86****few years ago**


PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|------------------------|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|---|--|--|--|

| | | | | | |
|--|--|---|--|---|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
|--|--|---|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
|---|--|--|--|---|--|

| | |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19____, to 6/28/86 , 19____, that (I) (we) last saw the deceased alive on 6/28/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
|---|--|

| | | | | | | | |
|---|--|---------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE
 | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/28/86 | |
|---|--|---------------------|--|--|--|------------------------------------|--|

| | | | |
|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OSOTH LEKABUL | | 22e. ADDRESS
7425 Arlington Rd Bethesda Md | |
|---|--|--|--|

| | | | | | | | |
|---|--|----------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
7-2-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
|---|--|----------------------------|--|------------------------------------|--|--|--|

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Tindon-Rudner | |
|--|--|-------------------------------|--|---|--|--|--|

MEDICAL CERTIFICATION

OKED TO Release per ME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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00-09678

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 4 8
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ESTHER SILVER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-7-86 | | 2b. HOUR
7-05A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-1-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Weingrad | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Claire (unknown) | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
174-50-8443 | | 17. INFORMANT
ADDRESS
Jack Fairman 7929 Mandan Rd. #103 Greenbelt, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock & asystole
DUE TO, OR AS A CONSEQUENCE OF
(b) MI
DUE TO, OR AS A CONSEQUENCE OF
(c) 2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7/86 19 86 to 6/7 19 86 , that (we) last saw the deceased alive on 6/7/86 19 86 , and that (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
6/7/86 | | 22d. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Gra Tanher | | 22f. ADDRESS
10701 George Washington Blvd. Silver Spring MD 20902 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 9, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Montefiore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fox Chase, Pennsylvania |
| 24. FUNERAL DIRECTOR
NAME
Goldstein Fun'l Directors | | ADDRESS
6410 N. Broad St. Phil., Pa. 19126 | | 25a. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

95390-00

UNITED STATES DEPARTMENT OF AGRICULTURE



00-10588

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 7 3 4 9

| | | | | | |
|---|--|---|------------------------------------|--|---------------------|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| SEVERINAS | | 6 21 1986 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR | IF UNDER 24 HRS. |
| Male | Caucasian | February 2, 1920 | 66 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | | |
| Lithuania | Lithuania | WIDOWED | DIVORCED | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | 733 Anderson Avenue | Auto Mechanic | | Auto Repairs | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Montgomery | Rockville | YES X NO | 733 Anderson Avenue/ 20850 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Not available | | Not available | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 579-58-4021 | | Mr. Bruno Sirtautas, Son,
737 Anderson Ave., Rockville, MD. 20850 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES X NO |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2 | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner | | | | | |
| Autopsy X Inspection Inquiry and in my opinion | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John E. Smialek, M.D. | | Chief | | 6/2/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Baltimore, Md. 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| Cremation | | June 24, 1986 | Metropolitan Crematory | | Alexandria Virginia |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD. | | JUN 26 1986 | | John Davidson-Randall | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

NOTICE

10/10/10



Handwritten mark or signature.



00-09797

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17850

| | | | | | | | | | | | | | | | |
|--|--------------|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST <u>Lynn</u> | | MIDDLE <u>Alison</u> | | LAST <u>Slosberg</u> | | 2a. DATE KNOWN OF DEATH | | MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> | | 2b. HOUR | | | |
| <u>Lynn</u> | | <u>alison</u> | | <u>Slosberg</u> | | | | <u>6</u> <u>11</u> <u>19</u> <u>86</u> | | <u>11:00</u> | | <u>PM</u> | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| <u>Female</u> | <u>white</u> | <u>3</u> <u>22</u> <u>50</u> | | <u>36</u> YRS. | | MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | | | <u>6</u> <u>13</u> <u>19</u> <u>86</u> | | <u>9:15</u> <u>AM</u> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| <u>Washington, D.C.</u> | | <u>U.S.A.</u> | | | | <u>Montgomery</u> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| <u>Chevy Chase</u> | | <u>5500 Friendship Blvd.</u> | | <u>Secretary</u> | | <u>Office</u> | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| | | | | <u>MD</u> | | | | <u>Montg.</u> | | | | <u>Chevy Chase</u> | | | |
| | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | | | | | |
| | | | | | | | | <u>5500 Friendship Blvd./20815</u> | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| <u>Hilbert</u> <u>--</u> <u>Slosberg</u> | | | | <u>Louise</u> <u>--</u> <u>Proser</u> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| <u>No</u> | | | | <u>215-58-9919</u> | | | | <u>William J. Slosberg, Washington, D.C.</u> | | | | <u>1168-25th St., N.W.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Gun Shot of Head.</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| <u>John Gawler</u> | | | | <u>John Gawler</u> | | | | <u>6-13-86</u> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| <u>John Gawler</u> | | | | <u>8218 Wisconsin Ave</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| <u>Cremation</u> | | | | <u>6/16/86</u> | | <u>Mt. Comfort Crematory</u> | | | | <u>Alexandria, VA</u> | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME ADDRESS | | | | | | | | | | | | | | | |
| <u>Joseph Gawler's Sons, Inc.</u> | | | | <u>JUN 18 1986</u> | | | | <u>John Gawler</u> | | | | | | | |
| <u>5130 Wisconsin Ave., NW, Washington, D.C. 20016</u> | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17
(VRA15 ME (5))
15M 2/80

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2025 RELEASE

2025 RELEASE

00-10244

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17851

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HAROLD L. SMITH | | | 2. DATE OF DEATH
MONTH DAY YEAR
6-18-86 8:23 PM | | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
06 02 1914 | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iowa | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
11307 Galt Avenue 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Luther Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETHEL McLaughlin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 482-01-1547 | 17. INFORMANT
NAME ADDRESS
Marcella A. Smith, Wife Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost
Cardiac Arrest
Severe coronary artery dis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Senere coronary artery dis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6/18/86 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (1) this hospital) attended to the deceased from 6/18/86 to 6/18/86 , that (1) (we) last saw the deceased alive on 6/18/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) I did not see the deceased after death. | | | | | |
| 27a. SIGNATURE
Alan I. Kermaier | | 27b. DEGREE
MD | | 27c. DATE SIGNED
6/19/86 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN I. KERMAIER | | 27e. ADDRESS
10313 Georgia Ave. S.S. MD 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 21, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | |
| 24. FUNERAL DIRECTOR
(NAME)
Francis J. Collins, Jr. | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
| 25c. ADDRESS
500 University Blvd. West Silver Spring, Md. | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by police.

9-8-32-31-3

11/14/32

11/2-11/11

11/201-0



James M. Smith
1814 to 1890

0-2 81/3

11/1/32

11/1/32

11/1/32

11/1/32

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17852

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. DATE OF ESTI-MATED DEATH | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MARIE E. SMITH | | F | | W | | JUNE 20, 1900 | | JUNE 20, 1900 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| WASHINGTON, D.C. | | USA | | | | MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| OLNEY | | MONTGOMERY HOSP | | H. MAKER | | HOME | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| MD. | | MONT. | | SANDY SPRING | | | | 16300 LAYHILL ROAD 20860 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| CHARLES - EBEL | | MARIE AMELIA EGLOFF | | NO | | 220-44-4826 | | ROBERT E. L. SMITH Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | None | | None | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22c. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22d. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22e. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | JULY 3, 1986 | | ROCK CREEK CEMETERY | | WASHINGTON, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE REC'D. BY REGISTRAR | | 25d. REGISTRAR'S SIGNATURE | |
| FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | JUL 2 1986 | | Jana Davidson | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-#4
25M

BP
DHMH - 17
(VR A15 ME (5))

BULL. MATH. J. 1958

00-10721

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 5 3
REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOTTIE J. SNYDER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 22, 1986 | | 2b. HOUR
6:07 PM | | | | | | |
| SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 6, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
86 | | 8. IF UNDER 24 HRS
HOURS MIN.
6:07 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Apstein | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Notick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
070-32-3246 | | 17. INFORMANT
ADDRESS
Monroe V. Snyder, Son, 1500 Northcrest Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH
20904 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
osteomyelitis sternum | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 , 19 85 , to 6-22 , 19 86 , that (I) (we) lost saw the deceased alive on 6-22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Donald L. Bucy | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Jun. 24, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald L. Bucy / S.W. Jones | | | | 22e. ADDRESS
809 Viers Mill Road, Rockville, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jun. 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Cty., Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.W. CHAMBERS CO., 9655 Ga. Ave., S.S. Md. 20910 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 27 1986 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson | | | | | |

BP

1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

2. The second part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

3. The third part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

4. The fourth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

5. The fifth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

6. The sixth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

7. The seventh part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

8. The eighth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

9. The ninth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

10. The tenth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St.

00-09878

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

J 7 8 5 4

| | | | | | | | | | | | | | | | | | |
|--|-----------|--|--|---|--|---|--|---|--|--------------------------------|--|-------|--|------|--|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH | | DAY | | YEAR | | 7b. HOUR
P M | |
| Karl | | | | | | Sollner | | | | 6-14 | | 19 | | 86 | | 8:00
P M | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| Male | Caucasian | January 9, 1903 | | 83 YRS. | | | | | | June 14, | | 19 | | 86 | | 8:20
P M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Austria | | United States | | | | Montgomery County, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Chevy Chase | | 3714 Manor Road | | Chemist | | Research | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Montgomery | | Chevy Chase | | | | 3714 Manor Road / 20815 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Anton | | Sollner | | Julie | | Karplus | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | - | | 215-38-4953 | | Mrs. Herta Sollner, Wife, Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Drug Overdose | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | Cerebral Vascular Accident | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | M.D. Deputy | | MEDICAL EXAMINER | | DATE
SIGNED | | June 14, 1986 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | John Tauber | | ADDRESS | | 8218 Wisconsin Avenue
Bethesda, Maryland 20814 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Cremation | | June 16, 1986 | | Metropolitan Crematory | | Alexandria Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | Robert A. Humphrey | | P.A., 7557 Wisconsin Avenue, Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25A

BP
DHMH - 17
(VR A15 ME (5))

JUN 19 1986

00-500078



WMOB WIRT-2412

REBIT HQ-TOD X06

00-09827

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17855

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JOHN Peter SOLTYSIAK Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 16 86 | | 2b. HOUR
12:05A M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 6, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
American | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Naval Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
USN | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Peter Soltysiak | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Antonette Marzecki | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes 1919-1957 | | 16b. SOCIAL SECURITY NO.
213-40-9161 | | |
| 17. INFORMANT
Helen N. Soltysiak | | ADDRESS
Item 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Lung
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Diabetes mellitus, Sanguine Heart Failure, CVA | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/6 , 19 86 , to 6/16 , 19 86 , that (I) (we) last saw the deceased alive on 6/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Dr. L. L. Moore | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELSA J. MARTINEZ M.D. | | 22e. ADDRESS
8808 HIDDEN HILL LANE POTOMAC | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Ft. Meyer Virginia | | |
| 24. FUNERAL DIRECTOR NAME
Olin L. Molesworth, P.A., Damascus, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | | 25b. REGISTRAR'S SIGNATURE
J. L. Davidson | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-00000

| | | | | |
|-----------|-----------|--------------|--------------------|-----------------------|
| Yes | 1919-1927 | 213-40-9101 | Helen M. Holmstrom | Dec 13 |
| Peter | Polish | Anderson | Harvard | |
| Harvard | Monte. | Harvard | X | 2443 Ridge Road 10072 |
| Rockville | American | White | Oct. 6, 1922 | 86 |
| Harvard | White | Oct. 6, 1922 | 86 | Montgomery County |

CHITTY

Serial 0/1/30 Arlington National Ft. Meyer Virginia
John L. Olesworth, P.A., Harwood, Md.

10
00-10431

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 86 17856
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DANNY EUGENE SPRUILL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JUNE 17 1986
2b. HOUR
3:03 P^M | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 26 1947 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
38 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TEXAS | | 9. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 12. CITY OR TOWN OF DEATH
BETHESDA | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. NAVY | | 15. KIND OF BUSINESS OR INDUSTRY
DEFENSE | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
VIRGINIA | | 16b. COUNTY
VIRGINIA BEACH | | 16c. CITY OR TOWN
VIRGINIA BEACH | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS / ZIP CODE
929 TIGERTAIL ROAD 23454 | |
| 17. DECEASED'S NAME
FIRST MIDDLE LAST
WILLIE EUGENE SPRUILL | | | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NINNIE VEE STEPHENSON | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 19b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1967-1986 | | 19c. 464-76-4653 | | 20. INFORMANT ADDRESS
SHARON L. SPRUILL, 929 TIGERTAIL ROAD, VIRGINIA BEACH, VA 23454 | | | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MALIGNANT MEDIALSTINAL MASS - GERM CELL TUMOR
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 22a. DATE OF OPERATION | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 22c. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 24a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 24b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 25. I certify that (I) (this hospital) attended the deceased from MAY 16 , 19 86 , to JUNE 17 , 19 86 , that (I) (we) lost saw the deceased alive on JUNE 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 26. SIGNATURE
<i>Antonio A. Calleja</i> | | DEGREE | | | | 27. DATE SIGNED
18 JUN 86 | | | |
| 28. PHYSICIAN'S NAME (TYPE OR PRINT)
G. A. CALLEJA, LT, MC, USNR | | 29. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | |
| 30. BURIAL, CREMATION, REMOVAL
(SPECIFY)
removal | | 31. DATE
6-20-86 | | 32. NAME OF CEMETERY OR CREMATORY
Kellum Funeral Home | | 33. LOCATION
CITY OR TOWN COUNTY STATE
Virginia Beach, Va. | | | |
| 34. FUNERAL DIRECTOR
NAME
Marshall's Funeral Home
ADDRESS
4217 9th St NW, Washington, D.C. | | 35. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 36. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 5 7
REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELAINE STAIR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 28, 1986 | | 2b. HOUR
11:40a |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 25, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5225 Pooks Hill Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
5225 Pooks Hill Rd., 20814 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Gornet | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Pollack | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
083-20-5040 | | 17. INFORMANT
Bethesda, Md., 20814
Jacqueline Turner; 5225 Pooks Hill Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LONG CHRONIC with Pleural Metastases
DUE TO, OR AS A CONSEQUENCE OF (c) 16 MONTHS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Congestive Heart Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from Sept 1983 to 6/28 86 , that (1) we last saw the deceased alive on May 1986 , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
Gary Fisher MD
DEGREE | | | | 22c. DATE SIGNED
June 28, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARY FISHER, M.D. | | | | 22e. ADDRESS
5530 Wisconsin Ave., Chevy Chase, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
7-1-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. Falls Church, Virginia | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR
JUL 03 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | 25a. DATE REC'D. BY REGISTRAR
JUL 03 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE
John Fisher | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Properly completed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8617858 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Earl Roy Standifer | | | | | | | | June 15 '86 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | White | | Jan. 16 1929 | | 57 YRS | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Montgomery | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Gaithersburg | | 42 W. Deerpark Drive #103 | | Landscaping | | Florist | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE #103 | |
| Md. | | Montgomery | | Gaithersburg | | | | 42 W. Deerpark Drive (20877) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| James Edward Standifer | | Kitty Hazel Goins | | Yes | | 1951-1956 | | Bobbie J. Standifer Gaithersburg, Md. 20877 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Respiratory Arrest | | DUE TO, OR AS A CONSEQUENCE OF (b) | | Respiratory Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (c) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | Emphysema | | 6 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 11a | | Lung carcinoma | | | | | | 8 yr. | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-11 19 86 to 6-15 19 86, that (I) (we) last saw the deceased alive on 4-26 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Frank J. Moyo, MD | | 22c. DATE SIGNED 6-16-86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Moyo, MD | | 22e. ADDRESS 16220 Frederick Rd. #213 Gaithersburg, Md. 20877 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery Cheltenham Prince Geo. Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Gartner Sandison F.H. Gaithersburg, Md. 20877 | | 316 E. Diamond Ave., | | 25a. DATE REC'D. BY REGISTRAR JUN 20 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 5 9
REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ernest Hugo Steigerwald | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 22, 1986 | | 2b. HOUR
8:00 P.M. |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
September 3, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9405 Five Logs Way | | 12a. USUAL OCCUPATION
(OF WORKING LIFE)
Mechanical Engineer | 12b. KIND OF BUSINESS OR INDUSTRY
Nuclear Power Plants | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Franz Steigerwald | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hildegard Steigerwald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | 17. INFORMANT
ADDRESS
Mrs. Thekla Steigerwald, Wife, Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pancreatic Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1986</u> to <u>Present</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>March 15, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>G. Hallick</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>6/22/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>GALEN HALLICK</u> | | 22e. ADDRESS
<u>11125 Rockville Pike, Rockville, Md 20852</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 26, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
Funeral Homes,
P.A., 300 W. Montgomery Ave., Rockville, MD. | | 25a. DATE REC'D. BY REGISTRAR
<u>JUN 26 1986</u> | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson</u> |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be called.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17860

| | | | | | |
|--|---------|---|-------------------|---|---------------------|
| 1- FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH | | 21. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 20. DATE KNOWN OF DEATH | | 21. HOUR | |
| Grace D. Sterne | | 6/22 1986 | | P. M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Female | White | May 21, 1907 | 79 YRS. | MONTHS | DAYS |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| Boston, Mass. | | Silver Spring | | 3612 Edelman Terrace | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. MARRIED | | 14. BALTIMORE CITY OR COUNTY OF DEATH | |
| USA | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | Montgomery County | |
| 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 16. KIND OF BUSINESS OR INDUSTRY | | 17. DATE OF DEATH | |
| Homemaker | | | | 6/25 1986 | |
| 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 19. CITY OR TOWN | | 20. STREET ADDRESS | |
| Maryland | | Montgomery | | Silver Spring | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 20906 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. INFORMANT | |
| John DeRoo | | Annie Drummond | | Son Rockville, Maryland 20853 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 17b. SOCIAL SECURITY NO. | | 17c. ADDRESS | |
| No | | 216-46-1892 | | Theodore D. Sterne 13218 Dumbarton Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Acute myocardial disease. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John S. Rogers, M.D. | | Deputy | | 6/25/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 1919 Seminary Road | |
| | | | | Silver Spring, Montgomery County, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | June 25, 86 | | Metropolitan Crematory | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis J. Collins, Jr. | | JUN 30 1986 | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. IF YOU HAVE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH · 17
(VR A15 ME (5))

100% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-09146

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8617861 | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Mildred S. Stevens. | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 7, 1986 | | 2b. HOUR
3:03 P | |
| 3. SEX
Female. | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 26, 1904 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
13729 Mills Silver Sprg. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired. D. C. A. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland. | | 13b. COUNTY
Montg. Co. | | 13c. CITY OR TOWN
Silver Sprg. Md. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Willis Warner. | | 15. MOTHER'S MAIDEN NAME
Dorothy Zeidler. | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, UNKNOWN) No. | | 16b. SOCIAL SECURITY NO.
579-46-3260 | |
| 17. INFORMANT
Mary Lou Mahaney. | | ADDRESS
13729 Mills Ave. S. S. Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Pancreas</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-16-86</u> to <u>6-7-86</u> , that (I) (we) last saw the deceased alive on <u>5-16-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Robert Kramer</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6-08-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT KRAMER | | | | 22e. ADDRESS
10313 Georgia Ave S.S. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial. | | 23b. DATE
June 10, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Riggs Rd. Adelphia | | 23d. LOCATION
CITY OF BALTIMORE CO. Md. | |
| 24. FUNERAL DIRECTOR
<u>Takoma Funeral Home, Inc.</u> | | 25. DATE REC'D. BY REGISTRAR
JUN 11 1986 | | 25a. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• • • • •

• **CHINA'S NEW LEADERS** = LI JIANGPING

0-08492

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617862

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|--|---|--|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT) IRVING STOLL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6. 1. 86 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 24, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.Y. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retailer | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6111 Montrose Road 20852 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
n/a | | 17. INFORMANT
Ed Stoll (son) | |
| | | | | 17a. ADDRESS
12408 Silver Birch Lane Laurel, Maryland 20708 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) RENAL FAILURE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)
PERITONITIS | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/30, 1986 , to 6/1, 1986 , that (I) (we) lost saw the deceased alive on 6/1, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (our) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
6/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TERMS SCHWAPP MD | | 22e. ADDRESS
1161 New Hampshire Ave Silver Spring MD 20901 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 4, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Sharon Gardens | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Valhalla, New York | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ives-Pearson F.H., Falls Church, Va. 22046 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

21/11/1911

21372

[Faint handwritten signature]

Handwritten signature: *James M. Smith*

1907

2000-2001

1000

230

2310

2000

1221

34-100000

72 5 2006

00-09708

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17863

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST Charles MIDDLE M. LAST Stuart, Sr. | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| CHARLES M. STUART | | | | 6-1-86 | | 9:00 | | AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | White | Nov. 15, 1900 | | 85 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | USA | | | Montgomery County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda MD | SUBURBAN HOSPITAL | | | Highway Contractor | | | Self Employed | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | Montgomery | | Chevy Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6204 Brookside Dr./20815 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| John Calvin Stuart | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 252-09-4308 | | Julia W. Stuart, Same address as #13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ARTERIOSCLEROTIC (HEART DISEASE) 15 YRS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | | | | | |
| CARCINOMA OF COLON | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/84 19 to 6/1 1986, that (I) (we) lost the deceased on 6/1 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (it) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| THOMAS F. O'CONNOR | | MD | | | | 6/2/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| | | | | 8218 WISCONSIN AVE BETHESDA | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | 6/3/86 | | Mt. Comfort Crematory | | Alexandria, VA | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | | JUN 09 1986 | | Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

[illegible]

00-11092

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 8 6 4
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank Lee SWAIM, Jr. | | | 20. DATE OF DEATH
MONTH DAY YEAR
June 27, 1986 | | 2b HOUR
9:30 PM |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 12, 1930 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10 CITY OR TOWN OF DEATH
Damascus | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10925 Long Meadow Dr. | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Food Facility Design Consultant | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Maryland | | 13b COUNTY
Montgomery | 13c CITY OR TOWN
Damascus | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Frank Lee Swaim, Sr. | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Johnson | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korean | 17. INFORMANT
Helen G. Swaim, | | ADDRESS
Item 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC GASTRIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 mos |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (the hospital) attended the deceased from OCTOBER 28, 1985 to JUNE 27, 1986 that (I) (we) last saw the deceased alive on JUNE 17, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
James A. Brown | | DEGREE
M.D. | | 22c DATE SIGNED
6/28/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
James A. Brown, M.D. | | 22e ADDRESS
14800 Physians La., # 232, Rockville, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
July 2, 1986 | 23c NAME OF CEMETERY OR CREMATORY
West Union | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Freeport, Ohio |
| 24 FUNERAL DIRECTOR
Olin L. Molesworth, P.A., Damascus, Md. | | | 25a DATE REC'D. BY REGISTRAR
JUL 1 - 1986 | | 25b REGISTRAR'S SIGNATURE
<i>James A. Brown</i> |

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work" or "other traumatic event," the medical examiner must be notified of any

00-01002

| | | | | |
|----------|-----------------------|---------------------------------|-------------------|-----------------------------|
| Frank | Lee | SWAIN, Jr. | June 27, 1980 | 9:30 PM |
| Male | White | Sept. 12, 1930 | 25 | |
| Ohio | USA | x | Montgomery County | |
| Damascus | 10925 Long Meadow Dr. | Food Facility Design Consultant | | |
| Maryland | Montgomery | Damascus | x | 10925 Long Meadow Dr. 20072 |
| Frank | Lee | SWAIN, Sr. | William | Johnson |
| Yes | Korean | 299-24-7107 | Helen G. Swain, | Item 13 |

James A. Brown, M.D.
11800 Physicians Ia., # 232, Rockville, Md.
Bristol July 2, 1986 West Union
Olin L. Moleworth, P.A., Damascus, Md.
Freeport, Ohio

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

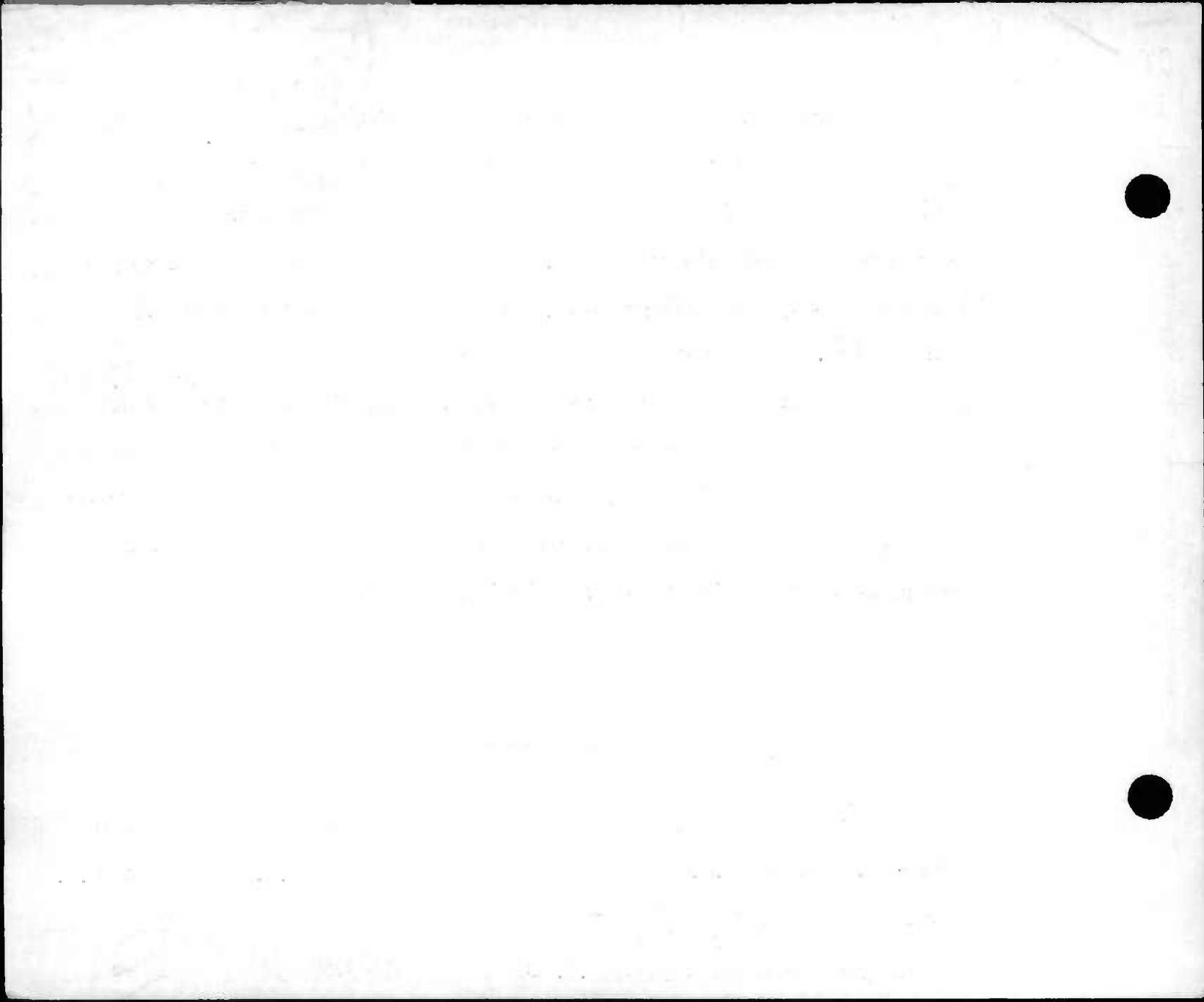
| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| FIRST MIDDLE LAST | | Male | | Black | |
| Alfred Lloyd Sweeney | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MONTH DAY YEAR | | June 21, 1918 | | 67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Ohio | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | 1131 University Blvd. | | Columist | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Montgomery | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | yes WW II | |
| John H. Sweeney | | Mary Walkinshaw | | 16b. SOCIAL SECURITY NO. | |
| | | | | 284-16-0564 | |
| | | 17. INFORMANT | | ADDRESS | |
| | | Sheila L. Sweeney | | 10909 Amherst Avenue | |
| | | | | Wheaton, Md. 20902 | |
| | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| | | | | PART I. DEATH WAS CAUSED BY: | |
| | | | | IMMEDIATE CAUSE (a) Myocardial Infarction | |
| | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | 24 hours | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (b) Congestive Heart Failure | |
| | | | | 6 months | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (c) Atrial Fibrillation | |
| | | | | 1 year | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | |
| | | | | Hypertensive Heart Disease; Gouty Arthritis; Diabetes | |
| | | | | 19a. DATE OF OPERATION | |
| | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | | | | 21b. TIME OF INJURY | |
| | | | | HOUR A.M. MONTH DAY YEAR | |
| | | | | P.M. 19 | |
| | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | | | 21d. INJURY OCCURRED | |
| | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | | | 21f. LOCATION | |
| | | | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | 22a. I certify that (I) (this hospital) attended the deceased from November 25, 1952, to June 13, 1986, that (I) (we) last saw the deceased alive on June 13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do) not see the body after death. | |
| | | | | 22b. SIGNATURE | |
| | | | | DEGREE | |
| | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| | | | | 22c. DATE SIGNED | |
| | | | | June 17, 1986 | |
| | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | | | 22e. ADDRESS | |
| | | | | Edward C. Mazique, M.D. | |
| | | | | 908 Kennedy Street, N.W. Washington, D.C. | |
| | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| | | | | 23b. DATE | |
| | | | | June 19 1986 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | | | Fort Lincoln | |
| | | | | 23d. LOCATION | |
| | | | | Brentwood, Maryland | |
| | | | | 24. FUNERAL DIRECTOR | |
| | | | | NAME ADDRESS | |
| | | | | McGuire Funeral Service | |
| | | | | 7400 Georgia Avenue Washington, D.C. 20012 | |
| | | | | 25a. DATE REC'D. BY REGISTRAR | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | JUN 20 1986 Julia Davidson-Rendall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



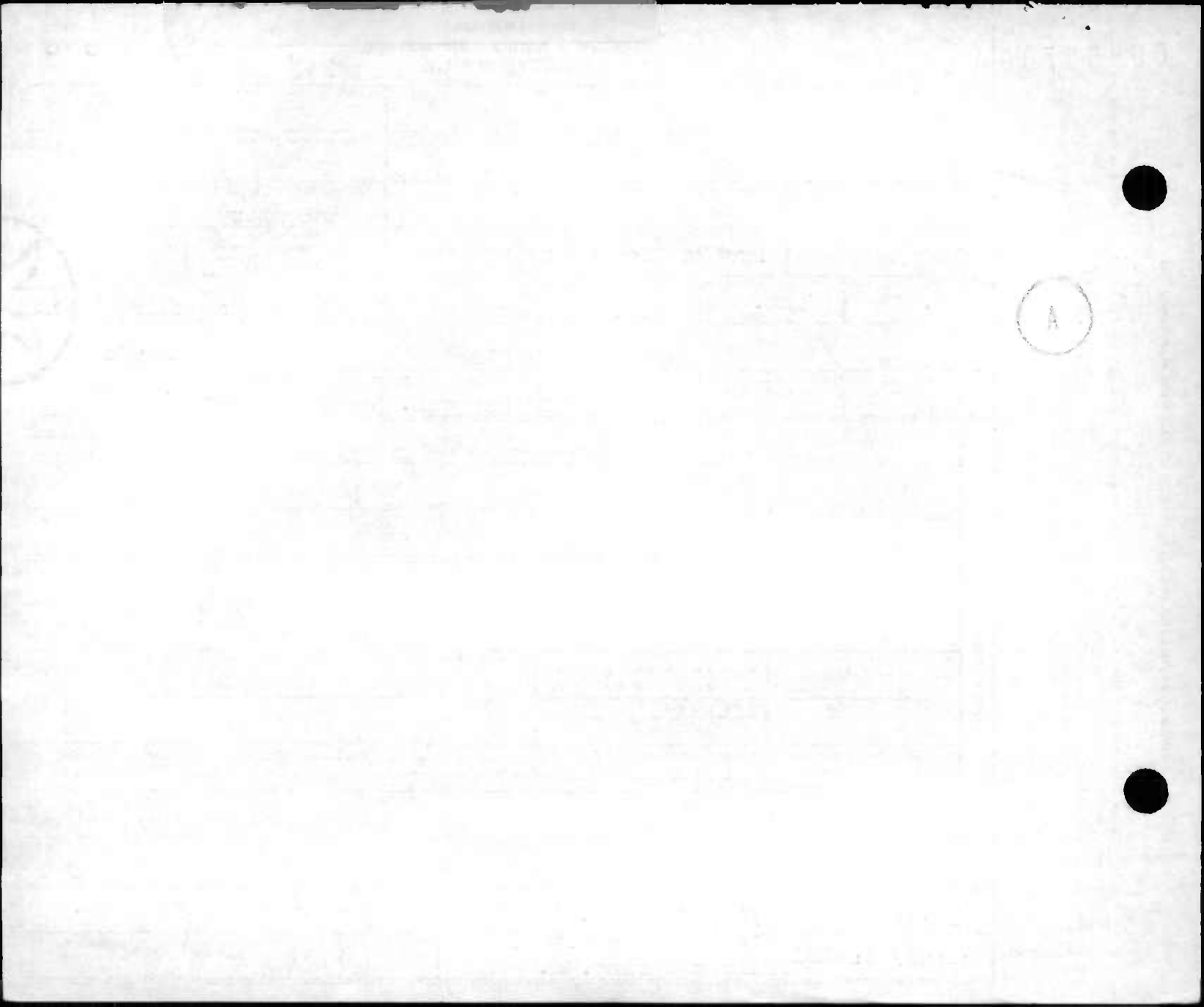
00-09780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 86 17866 | |
|--|--|--|---|---|--|--|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Ruth C. Sweeney | | | 2a. DATE OF DEATH MONTH DAY YEAR
6-15-86 | | | 2b. HOUR
8:25 PM | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
10 19 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
BROOKE GROVE Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15737 New Hampshire Avenue 20904 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Harlow | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Davis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
None | | 16b. SOCIAL SECURITY NO.
577 09 7623 | | 17. INFORMANT Same as above
B Henry I. Sweeney (Husband) | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic bronchitis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/15/86</u> 19 <u>86</u> to <u>6/15/86</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>6/15/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE | | | | 22c. DATE SIGNED <u>6/15/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. H. L...</u> | | | | 22e. ADDRESS <u>1801 P. Philip Dr. Olney Md 20852</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION
Brentwood PG MD. | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | | | | 11800 New Hamp. Ave.
Silver Spring Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Clifton L. Talley | | | | June 20, 1986 | | 6:10A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | Black | MONTH DAY YEAR
July 13, 1913 | | 72 | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | USA | | | Montgomery | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Olney | Montgomery General Hospital | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | | |
| MD | | Montg. | | 14540 Jones Lane / 20878 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Richard M. Talley | | Laura Lee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | Herman Talley | | 11 Martins Lane
Rockville, MD 20850 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cor pulmonale, respiratory failure</u> 2 wks
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> yrs
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 1975 to June 20 1986, that (I) (we) last saw the deceased alive on June 19 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Robert Millman, MD | | MD | | 15 Deer Park Dr Gaithersburg, MD 20877 | | 6/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 6-25-86 | | Poplar Grove Cem. | | Gaithersburg, Montg, MD | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George R. Snowden | | Rockville, MD 20850 | | JUN 25 1986 Julia T. Snowden | | | |

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Office

March 10



0-10321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

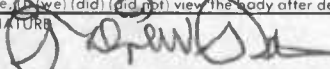
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 6 8
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) HAROLD J. TRAUGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/22/86 | | 2b. HOUR
1:15 A.M. |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
10-2-23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DEPT PUBLIC WORKS | | 12b. KIND OF BUSINESS OR INDUSTRY
P.G. COUNTY GOV. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PRINCE GEORGE | 13c. CITY OR TOWN
COLLEGE PK. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
TRAUGER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALTA | | 17. INFORMANT ADDRESS
(SAME AS #13 ABOVE) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES WW II | | 16b. SOCIAL SECURITY NO.
211-12-2422 | | 17. INFORMANT ADDRESS
MRS. MARGARET A. TRAUGER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ASPIRATION PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) SMALL CELL LUNG CANCER | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 WEEKS
6 WEEKS
6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
RENAL INSUFFICIENCY | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from JUNE 1 , 19 86 , to JUNE 22 , 19 86 , that (1) (we) last saw the deceased alive on JUNE 21 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
 | | DEGREE
M.D. | | 22c. DATE SIGNED
6/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RALPH V. BOCCIA, M.D. | | 22e. ADDRESS
#23V
14800 PHYSICIANS LN. ROCKVILLE 20850 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
6/27/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
MARYLAND VET. CEM. | |
| 23d. LOCATION
CITY OR TOWN
CHELTENHAM TOWNSHIP MD | | 23e. DATE OF DEATH
JUN 24 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home John Walter | | ADDRESS
254 Canal St. N.E. DC | | 25. DATE OF DEATH
JUN 24 1986 | |

BP

151945

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17869
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN GRIFFIN THOMAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6 4 86 | | 2b. HOUR
1:55 PM |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
2 1 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO MD | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4521 EAST-WEST HWY #405 BETHESDA MD 20814 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RESIDENT MANAGER - APARTMENT | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
BETHESDA | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4521 EAST-WEST HWY #405 20814 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES H. GRIFFIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE HOLIDAY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-26-5094 | | 17. INFORMANT
MARIAN MCKNIGHT 4521 EAST-WEST HWY #312 BETHESDA MD 20814 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mos. |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 28, 1986 to June 4, 1986 that (we) lost the deceased and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
6/4/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Fred Smith | | 22e. ADDRESS
5401 Western Ave., N.W. | |

| | | | |
|--|--------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
cremation | 23b. DATE
June 5, 86 | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hunt Funeral Home 2801 7th St. N.E.D.C. | | 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-17-11

24/10/17

70 11111

00-08931

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17870

| | | | | | |
|--|------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
David Wolcott Toll | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
6 4 86 | | 2b. HOUR
12:25 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 18 61 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
25 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rear of 8005 Connecticut Avenue | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)
Student | |
| 13a. STATE
MD | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Chevy Chase | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David R. Toll | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shirley -- Bisselle | | 16. SOCIAL SECURITY NO.
579-74-9365 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-74-9365 | | 17. INFORMANT ADDRESS
David R. Toll, Same address as #13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GunShot of Head</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (c) stating the <u>underlying cause lost</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE
<u>John Tauber</u> | | TITLE (SPECIFY)
M.D. <u>Dpt</u> | | DATE SIGNED
6-4-86 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | ADDRESS
8218 Wisconsin Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
6/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Crematory | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | 23d. LOCATION
CITY OR TOWN
Alexandria, VA | | 23e. DATE REC'D. BY REGISTRAR
JUN 10 1986 | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 10 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 301 W. BOSTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMM-17
(VR A15 ME (5))
15M 2/80

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00-087951

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17371

| | | | | | | | | |
|--|-------------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace MABEL | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
6 1 86 | | | 2b. HOUR
11:00 AM | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8-17-14 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
71 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
6 1 86 | 7d. HOUR
2:30 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Cabin John | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7711 MacArthur Blvd. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Cabin John | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7711 Mac Arthur Blvd. 20818 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Rooney | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Romaine Wright | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577 28 0361 | | 17. INFORMANT ADDRESS
William Via #3 Ericsson Rd. Cabin John, Md. 20818 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
John Tauber | | TITLE (SPECIFY)
Deputy | | M.D.
Bethesda | | DATE SIGNED
6-1-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | ADDRESS
8218 Wisconsin Ave | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mechanicsville Baptist Church Cemetery, Gordonville, Va. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | | 25b. REGISTRAR'S SIGNATURE
Julie Davidson-Randall | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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00-11016

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617872

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME FIRST MIDDLE LAST
RUBE VINICK | | June 21, 1986 | | 12:10pm | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
April 2, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Asst. Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Toys |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
14504 Kings Grant Street 20878 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Shlomo Chaim Vinick | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No ----- | | 16b. SOCIAL SECURITY NO.
150-01-9248 | | 17. INFORMANT ADDRESS
Sara Vinick, Wife; 14504 Kings Grant Street 20878 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Parkinsonism Dementia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 86 to 6/21 19 86, that (we) lost saw the deceased alive on 6/21 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Raymond Bass | | | | 22c. DATE SIGNED
6-21-1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS, M.D. | | | | 22e. ADDRESS
3941 Ferrara Drive; Wheaton, Md. 20906 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-24-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | 25a. DATE REC'D. BY REGISTRAR
JUN 25 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Tindler-Rudack | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

10-10-10



00-11254

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17873

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|-----------|--|--|---|--|------------------------------------|--|---|--|--------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | |
| Margaret | | I. | | Vonderembse | | | | 6-28 | | 19 86 | | M | |
| SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Caucasian | May 21, 1948 | | 38 YRS. | | | | | | 6-28 19 86 | | 2:05 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington D.C. | | United States | | WIDOWED | | DIVORCED | | Montgomery County, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | Suburban Hospital | | Student | | Education | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Rockville | | YES X NO | | 700 Burgundy Drive | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Carl | | Eunice | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 214-60-1278 | | Mother | | 700 Burgundy Dr. | | | | | | | |
| | | | | Eunice B. Vonderembse | | Rockville MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| 8122 IMMEDIATE CAUSE (a) Multiple Injuries | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | YES X NO | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | 11:00xx 6-27 1986 | | | | subject riding motorized device struck by auto | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK XX | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | street | | | | Viers Mill & Edmonston Dr., Rockville, Montgomery Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident XX, Suicide, Homicide, Undetermined manner. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| | | | | Assistant | | | | 6-29-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. | | | | 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | July 1, 1986 | | National Memorial Park | | | | Falls Church, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, M.D. | | | | JUL 2 1986 | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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BP

DHMH - 17
(VR A15 ME (5))

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DWDD

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MCTTCO



2

1987 JUL 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and take them to the funeral home. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

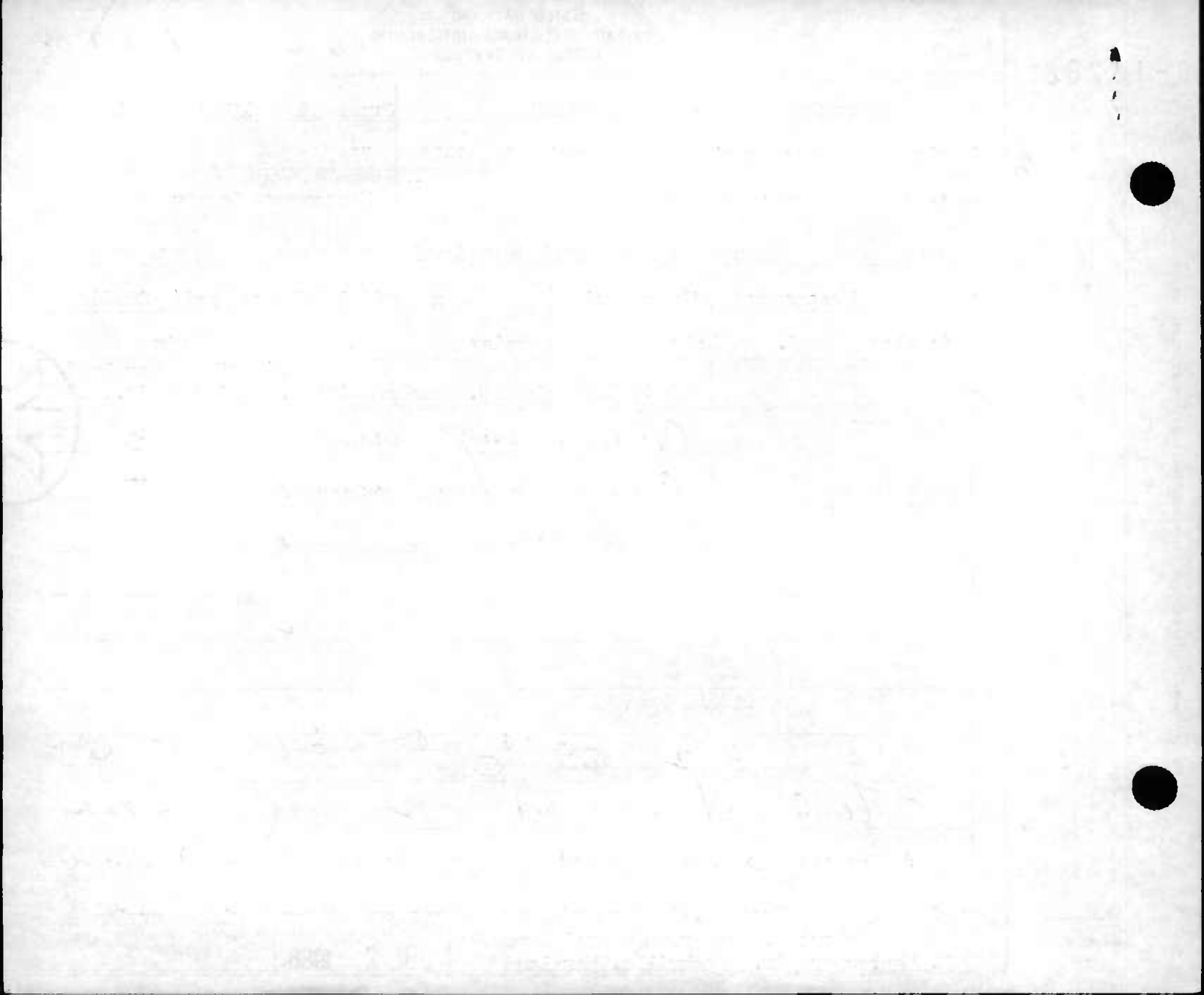
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorothy H. Walsh | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 20, 1986 | | 2b. HOUR
2:00 pm |
| 3. SEX
female | 4. RACE
caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
April 30, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
own home |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2601 Bel Pre Road/ 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nicholas J. Walsh | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisy Lee Muir | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
220 44 7553 | | 17. INFORMANT
ADDRESS
Rockville, Maryland
John C. Monahan, 401 E. Jefferson St., 20850 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Vascular accident
DUE TO, OR AS A CONSEQUENCE OF
(c) Sepsis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3
4 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6-20-86 to 6-20-86 , that (1) (we) last saw the deceased alive on 6-20-86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Michael D. Sulkin MD | | DEGREE
MD | | 22c. DATE SIGNED
6-20-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael D. Sulkin MD | | 22e. ADDRESS
1801 Prince Philip Dr/O'keefe | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 27, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | 25a. DATE REC'D. BY REGISTRAR
JUL 2 1986 | | 25b. REGISTRAR'S SIGNATURE
James Davidson | |
| 300 W. Montgomery Av., Rockville, Maryland | | | | | |



00-09531

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 3 7 5
REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Robert Wannan Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 11 1986 | | 2b. HOUR
7:30 a.m. |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 11 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1705 Gridley Lane | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Paymaster | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Interior |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1705 Gridley Lane 20902 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Wannan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ann Tait | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I 577-48-3369 | 17. INFORMANT
ADDRESS
Semmis P. Wannan Wife Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> 19 <u>86</u> to <u>6/11</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>B.N. Rosenbaum, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.N. ROSENBAUM, M.D. | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON, MD. 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
June 13, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr.
500 University Blvd. West Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR
JUN 16 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | |



THE COTTON FIBER

MADE IN AMERICA



00-10829

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8617870
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Ann V. Ward | | | 2a. DATE OF DEATH
June 23, 1986 | | | 2b. HOUR am
11:30 M | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 8, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1621 Bradley Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1621 Bradley Avenue / 20851 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Pedro | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jeanette Mojarity | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
Daughter | | ADDRESS
13609 Lewisdale Road
Clarksburg, Md. 20871 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Small Cell Carcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Right upper lobe lobectomy for Squamous Cell Carcinoma, Emphysema</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>6/22/86</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Small Cell Carcinoma of Lung</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/85</u> , 19____, to <u>6/23/86</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/22/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jeremy V. Cooke</u> | | | | | DEGREE
<u>MD</u>
ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
June 23, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeremy V. Cooke, M.D. | | | | | 22e. ADDRESS
10400 Connecticut Avenue
Kensington, Maryland 20895 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
June 26, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
ADDRESS Funeral Homes, P.A.
300 West Montgomery Ave. Rockville, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 30 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

BP

1

00-10984

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17877

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SARAH HAZEL WARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 20 1986 | | | 2b. HOUR
1:15 P M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 20 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FLORIDA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
VIRGINIA | | | 13b. CITY OR TOWN
FAIRFAX | | 13c. CITY OR TOWN
SPRINGFIELD | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ELIJAH SWAIN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Margarite Pent | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
224-48-6487 | | | 17. INFORMANT
ADDRESS
ELOISE SOEL, 5402 CHARLOTTESVILLE ROAD, | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 27 19 86 , to JUNE 20 19 86 , that (I) (we) last saw the deceased alive on JUNE 20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. P. Mehegan | | | | | | DEGREE
MD | | 22c. DATE SIGNED
20 June 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. P. MEHEGAN, LT. MC, USN | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
June 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. Arlington, Virginia | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Paul D. Bower | | | | | | ADDRESS
1500 W. Braddock Rd. 22312 | | 25a. DATE REC'D. BY REGISTRAR
JUN 26 1986 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Deaton-Rodriguez | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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00-10240

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 6 1 7 8 7 8
REG. NO. | | | |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | 2a DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME FIRST MIDDLE LAST
FRANCIS WARNER | | | | 6-17-86 930/A M | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
8-4-90 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
95 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
Maryland | | | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Derwood | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Henry Gasser | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Reynolds | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
213-52-2494 | | 17 INFORMANT ADDRESS
Grandson William Hartman Same as 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>STATUS POST MYOCARDIAL INFARCT</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>AND CONGESTIVE HEART FAILURE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>RENAL FAILURE</u> | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-20-1986</u> to <u>6-17-1986</u> , that (I) (we) last saw the deceased alive on <u>6-16-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
MANGAL KATIKINENI | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MANGAL KATIKINENI | | 22e ADDRESS
3301 NEW MEXICO AVE
DC 20016 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
Jun. 21, 1986 | | 23c NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | |
| 24 FUNERAL DIRECTOR Francis J. Collins, Jr.
NAME ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b REGISTRAR'S SIGNATURE
Davidson-Randall | |

0-11568

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86
REG. NO.

17879

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | FIRST MIDDLE LAST
William S. Warner | | June 27, 1986 | | 9:23A M | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | MONTH DAY YEAR
02 01 1914 | | 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Indiana | | USA | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. INDUSTRY OR BUSINESS OR INDUSTRY | |
| Olney | | Montgomery General Hospital | | Treasurer | | of Elec. Co. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Montgomery | | Silver Spring | | 13e. STREET ADDRESS / ZIP CODE
15211 Elbridge Way 20906 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Thomas | | Ethel | | Yes | | WW II 578-07-5544 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>obstructive lung disease with complications</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u> | | 19. ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min
2 yr.
10 yr. | |
| Margaret K. Warner | | Wife Same as 13 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 24</u> , 19 <u>86</u> , to <u>June 27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| Frank J. Mayo | | 6-27-86 | | Frank J. Mayo MD | | 16220 Frederick Rd. 4213
Bethesda, Md. 20877 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | July 3, 1986 | | Gate of Heaven Cemetery Silver Spring | | Montgomery Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis J. Collins, Jr. | | JUL 7 1986 | | Julia Davidson Randall | | | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the funeral director's portion of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

RECEIVED
NOV 14 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.



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00-10656

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17880 | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ANNIE MAY WASHINGTON | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MONTH DAY YEAR
6 14 1986 | | 2b. HOUR
M
1:00 P. | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 14, 1934 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
52 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
6 14 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Silver Spring Motel | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Pvt Industry | | | |
| 13a. STATE
D. C. | | 13b. COUNTY | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4328 4th Street, N. W. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hickman Keyes | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Blocker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
249-52-0413 | | 17. INFORMANT
Doris W. Thompson | | | | ADDRESS Washington, D. C. 1750 Seaton St., N.W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple stab wounds
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 6 14 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject stabbed | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
motel | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7927 Georgia Ave., Silver Spring, Mont., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita Korell | | M.D. | | MEDICAL EXAMINER | | | | DATE SIGNED 6/15/86 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita Korell, M.D. | | ADDRESS 111 Penn St., Baltimore, Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
19 Jun 86 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
W. Ernest Jarvis Co., Inc. | | ADDRESS
1432 You St., N. W., Washington, D. C. | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Seaton-Rodman | | | | | |

MEDICAL CERTIFICATION

07 84 BP
25M
DHMH - 17
(VR A15 ME (5))

OVER MATHEMATICS

RECORD BOOK

Faint, illegible text and markings are visible across the page, likely bleed-through from the reverse side. Some faint words like "RECORD" and "BOOK" are discernible in the center.

00-09739

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

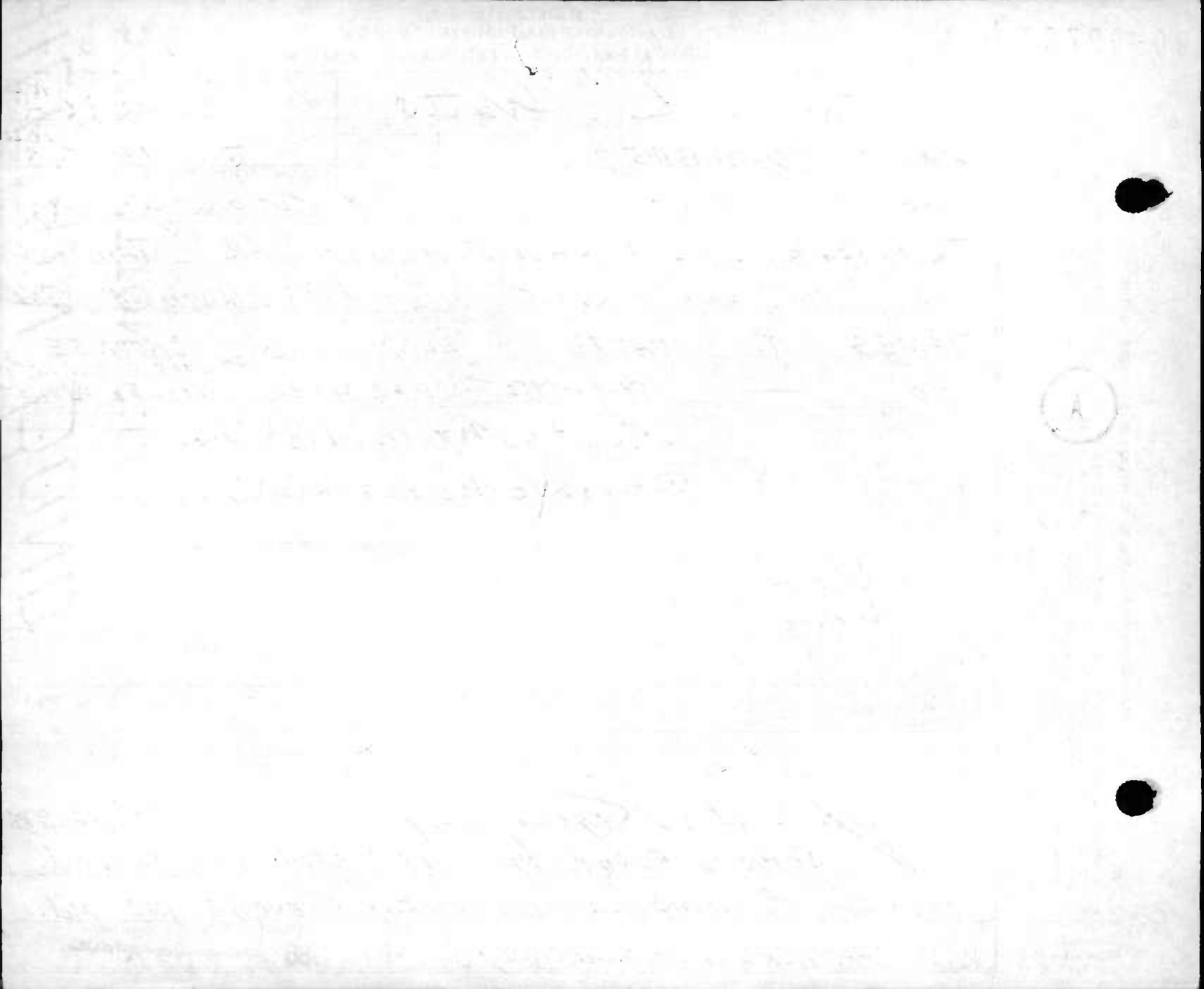
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17381 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas L Watts | | | | | | | | | | 2a. DATE KNOWN OF DEATH June 12, 1986 | |
| 3. SEX MALE 4. RACE WHITE 5. DATE OF BIRTH March 13, 1915 6. AGE (IN YEARS) 71 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | | | | | | | | 2b. DATE PRONOUNCED DEAD June 12, 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Tak Park. 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER 12b. KIND OF BUSINESS OR INDUSTRY PAINTING | | | | | | | | | | | |
| 13a. STATE Md. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4708 WILWYN WAY 20852 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST JAMES MIDDLE T. LAST WATTS 15. MOTHER'S MAIDEN NAME FIRST LUCY MIDDLE B. LAST CROUNSE | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 578-05-8752 17. INFORMANT THERESA L. HOLDER ADDRESS 4708 WILWYN WAY ROCKVILLE, MD 20852 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Div.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial Div.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers TITLE (SPECIFY) General M.D. MEDICAL EXAMINER DATE July 12, 1986 SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS MD. ADDRESS 1919 SEMINARY RD. S.S. MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION 23b. DATE JUNE 15, 1986 23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY 23d. LOCATION CITY OR TOWN RIVERDALE COUNTY PGC STATE MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. CHAMBERS ADDRESS CO. INC. SILVERSPRING, MD. 25a. DATE REC'D. BY REGISTRAR JUN 17 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | | | | | |

MEDICAL CERTIFICATION



00-08929

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8 0 1 7 8 8 2 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JULIUS LEON WEISBAUM | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
June 7 1986 | | 2b. HOUR
5 P.M. | |
| 3. SEX
MALE | | | 4. RACE
CAUCASIAN | | | 5. DATE OF BIRTH MONTH DAY YEAR
JAN. 10 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
81 | | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.Y.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
POTOMAC | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8314 SNUG HILL LA. POTOMAC MD | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ATTORNEY-RET. | | | 12b. KIND OF BUSINESS OR INDUSTRY
PVT. INDUST | | | | |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY
FLA. DADE | | | 13c. CITY OR TOWN
MIAMI BEACH | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
230-174th ST. MIAMI BEACH | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HAROLD WEISBAUM | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY (UNKNOWN) | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)
NONE | | | 17. INFORMANT
MR. BERTRAM WEISBAUM- | | | ADDRESS 8314 SNUG HILL LA. POTOMAC MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>glioblastoma multiforme</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/7</u> 19 <u>86</u> , to <u>6/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>GABRIEL JAFFE, MD</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
6/7/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GABRIEL JAFFE, MD | | | | | | 22e. ADDRESS
7500 Annapolis Pkwy Greenbelt MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
6-9-86 | | | 23c. NAME OF CEMETERY OR CREMATORY
SHARON GDNS | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
MIAMI FLORIDA | | | | |
| 24. FUNERAL DIRECTOR
DAN LAWSKY-GOLDBERG MEM. CHRS. INC
1170 ROCKVILLE PK. ROCKVILLE MD 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 10 1986 | | | 25b. REGISTRAR'S SIGNATURE
<u>G. J. Jaffe</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certificate from this permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

PHMH 16 50M 4/82
(VRA 15, 4)

98 001 1

Contract No. 100-000000

100-000000

100-000000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE REGISTRAR **Evelyn G. Wendel**

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN G. WENDEL | | 2a. DATE OF DEATH
MONTH 6 DAY 27 YEAR 86 | | 2b. HOUR
8:30 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 9 DAY 29 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NY | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Wash., | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | 12b. KIND OF BUSINESS OR INDUSTRY
NY Gov't. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6121 Montrose Rd. 20852 | |
| 14. FATHER'S NAME
FIRST Barnett MIDDLE Goorland LAST Goorland | | 15. MOTHER'S MAIDEN NAME
FIRST Masha MIDDLE Spi'vak | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
122-24-1881 | 17. INFORMANT
ADDRESS
Edward Wendel 840 NH Ave. NW Wash., DC | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **ASPIRATION PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **PARKINSONS DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 DAYS**10 YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

SENILE DEMENTIA ALZHEIMER'S TYPE

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (he) (this hospital) attended the deceased from 11/27 19 84 to 6/27 19 86 , that (he) (we) lost
saw the deceased alive on 6/27 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (he) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Steven Lipson MD | | DEGREE
MD | 22c. DATE SIGNED
6/28/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | 22e. ADDRESS
6121 MONTROSE RD, ROCKVILLE | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial-Removal | 23b. DATE
6/30/86 | 23c. NAME OF CEMETERY OR CREMATORY
Monteflore Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Queens Co. St. Albans, NY |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 WI Ave. NW Wash., DC 20016 | | 25a. DATE REC'D. BY REGISTRAR JUL 03 1986 25b. REGISTRAR'S SIGNATURE
<i>John T. ...</i> | |

BP _____

0-11216

Walter G. Wendel

D.

White

U.S.A.

White

Montgomery

X

WFO Gov't.

Clark

Hebrew Home of Greater Wash.,

Rockville

Oldi Montrose St.

X

Rockville

Montgomery

MD

Spokane

Spokane

Spokane

Barnett

122-24-1881

Ne

122-24-1881

Serial-removal 122-24-1881

Montgomery, Tenn.

Means Co. St. Albans, VT

Joseph G. Geller, Inc.
1230 W. Ave. N. Wash., DC 20016

00-09820

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8617884

| | | | | | | | | |
|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Verna G. Wessells</u> | | | 2a. DATE OF DEATH
MONTH <u>6</u> DAY <u>12</u> YEAR <u>86</u> | | 2b. HOUR <u>6:30</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Cauc.</u> | | 5. DATE OF BIRTH
MONTH <u>11</u> DAY <u>07</u> YEAR <u>05</u> | | 6. AGE
YRS <u>80</u> MONTHS <u>05</u> DAYS <u>05</u> HOURS <u>00</u> MIN. <u>00</u> | | |
| 7a. BIRTHPLACE
COUNTRY <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE <u>Maryland</u> | | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Wheaton</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>William</u> MIDDLE <u>Gray</u> LAST <u>Gray</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Rose</u> MIDDLE <u>Bowman</u> LAST <u>Bowman</u> | | 13e. STREET ADDRESS / ZIP CODE
<u>938 Grays Lane</u> <u>20902</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | | 16b. SOCIAL SECURITY NO.
<u>214-60-5622</u> | | 17. INFORMANT
<u>son</u> ADDRESS <u>730 Dennis Avenue</u>
<u>Gerry E. Wessells</u> <u>Silver Spring, Md. 20901</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 WEEK</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>FEB</u> 19 <u>86</u> to <u>12 JUNE</u> 19 <u>86</u> , that I (we) last saw the deceased alive on <u>11 JUNE</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Gooch MD</u> | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12 JUNE 86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>WALTER E. GOOCH MD</u> | | | | 22e. ADDRESS
<u>2309 SHOREFIELD RD WHEATON MD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>June 16, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Silver Spring Montgomery Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME <u>Francis J. Collins, Jr.</u>
<u>500 University Blvd., W. Silver Spring, Md.</u> | | | | 25. DATE REC'D. BY REGISTRAR <u>JUN 18 1986</u> 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

70
00-09535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17885

| | | | | | | | | | | | | | |
|---|-----------------------------|---|---|---|------------------|--|--|--|--|----------|--|--|--|
| 1- STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) Warren Reed West | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> June 8 1986 | | | 2b. HOUR OF DEATH
11:15 AM | | | | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 27 94 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
91 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
June 8 1986 | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | 24. HALL | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Professor | | | 12b. KIND OF BUSINESS
University Geo. Wash. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | | | 12a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Montgomery | | | 12c. STREET ADDRESS
15101 Glade Drive Apt. 3-G | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
15101 Glade Drive Apt. 3-G | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Marion Thomas West | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isloy Redmun | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes
(IF YES, GIVE WAR OR DATES) WW II | | | | 16b. SOCIAL SECURITY NO.
579-44-0878 | |
| 17. INFORMANT
Son | | | | ADDRESS
Washington, D.C. | | | | 17. INFORMANT
Thomas R. West 1000 Otis St. N.E. 20017 | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |

| | | | | | |
|--|--|-------------------------------------|--|-----------------------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
John P. Rogers | | TITLE (SPECIFY)
M.D. Dep. | | MEDICAL EXAMINER | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | DATE SIGNED
June 8 1986 | |

| | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
June 9, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 10 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |
| 500 University Blvd. West Silver Spring, Md. | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

20% COTTON 1885

WILLIAM
MILLER
D



20% COTTON 1885

WILLIAM
MILLER
D

20% COTTON 1885

00-09534

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17886

REG. NO.

| | | | | | | | | |
|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Vera Wharton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 10, 1986 | | | 2b. HOUR
2:00am | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 20 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12918 Estelle Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
12918 Estelle Road 20906 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lott Dearborn | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
071-01-2172 | | 17. INFORMANT
ADDRESS
Lawrence C. Wharton Husband Same As 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>coronary artery disease, atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 min</u>
<u>20 years</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
<u>left bronchial obstruction from acute aneurysm with left lung collapse</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1986</u> to <u>June 16, 1986</u> , that (I/we) last saw the deceased alive on <u>June 15, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we did not view the body after death). | | | | | | | | |
| 22b. SIGNATURE
<u>Mark Rosen</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Rosen | | | | 22e. ADDRESS
3941 Farnam Dr., Silver Spring, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
June 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr.
500 University Blvd. West Silver Spring, Md. | | | | 25a. DATE OF REGISTRATION
JUN 16 1986
REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1-10378

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 7 8 8 7

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
IRENE E WHITE | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 21 86 | | 2b. HOUR
8:50 A M | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
2 14 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
80 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DIRECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY
DAY CARE | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MARQUIS DANIEL WHITE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ETHEL BORIS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
290-03-8281 | | 17. INFORMANT ADDRESS
MURLENE N. PHILLIPS, DAUGHTER, SAME AS ITEM 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mins
6 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Peripheral Vascular Disease, Coronary Artery Disease, Aortic Insuff | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 14 19 86 to June 21 19 86 , that (I) (we) lost saw the deceased alive on June 21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Howard S. Goldstein MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
6/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard S. Goldstein MD | | | | | | STREET ADDRESS
4701 Randolph Rd, Rockville, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
6/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
COLUMBUS, OHIO | | |
| 24. FUNERAL DIRECTOR NAME
RICHARD RAPP, INC. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 24 1986 | | | |
| 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

MANUFACTURE

MADE IN

CHINA

CHINA

MADE IN

100%

COTTON FIBER

0-10137

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17888
REG. NO.

| | | | | | |
|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM T. Whitefield | | 2a. DATE OF DEATH
MONTH DAY YEAR 6/15/86 | | 2b. HOUR 12 P.M. | |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 4/14/05 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scotland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13,016 Pacific Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY
Religion |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST (unknown) MIDDLE LAST Whitefield | | 15. MOTHER'S MAIDEN NAME
FIRST Helen MIDDLE Thomson LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
27903 5314 | 17. INFORMANT ADDRESS
Sherry Roberts 13417 Tangier Place Rockville, Md 20853 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Metastasis
DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic Cell Carcinoma, Urinary Bladder - 2 years
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Bladder due to Prostatic Cell Carcinoma | | | | | INTERPRETATION INTERVAL
BETWEEN CAUSE AND DEATH
16 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Urinary Bladder due to Prostatic Cell Carcinoma | | | | | |
| 19a. DATE OF OPERATION
3/11/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bladder Cancer | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/15/86 to June 1986 , that (I) (we) lost saw the deceased alive on 6/15/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Timothy J. Tehan M.D. | | DEGREE M.D. | 22c. DATE SIGNED
6/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Timothy J. Tehan M.D. | | 22e. ADDRESS
8218 Wisconsin Avenue, Bethesda, Md 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6/18/86 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Janae W. Wilson | |

100-100000

NOTICE

1

00-T0455

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 17889

| | | | | | | | |
|---|--|--|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| KATE | | WIDOME | | June 18, 1986 | | 10:30 p.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR
Feb. 22, 1891 | | 95 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Russia | U.S.A. | | | Montgomery County, MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | 8201 16th Street, #1021 | | Homemaker | | Home | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | (20910) | |
| Maryland | Montgomery | Silver Spring | | 8201 16th Street, #1021 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Avrum Pearson | | Sarah Kaplan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 220-44-6693 | | Bethesda, Md. 20817 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CANCER OF THE COLON
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from Nov. 2, 1976, to June 18, 1986, that (we) last saw the deceased alive on June 11, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| CRAIG M. KESSLER | | | | M.D. | | June 19, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| CRAIG M. KESSLER, M.D. | | | | 2150 Penn. Avenue, N.W.; Washington, D.C. 20037 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 6/20/86 | | D.C. Lodge Cemetery | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE | | | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | JUN 23 1986 Julia D. D. Kessler | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

BP



George W. [illegible]

00-08897

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17890
REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MILTON E WILLIAMS | | 2a. DATE OF DEATH
MONTH DAY YEAR
6-2-86 | | 2b. HOUR
10³⁰ PM | |
| 3. SEX
male | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/11/12 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNKNOWN | | 8. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
montgomery MD. | | 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BEL PRE NURSING HOME | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | | 13. STREET ADDRESS / ZIP CODE
2601 BEL PRE ROAD 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | |
| 16b. SOCIAL SECURITY NO.
577-09-5953 | | 17. INFORMANT (CLERGY) ADDRESS
WASHINGTON, D.C. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CHRONIC CONGESTIVE HEART FAILURE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-27 , 19 80 , to 6-2 , 19 86 , that (I) (we) lost
saw the deceased alive on 6-2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bernard A. Fitzgerald MD | | DEGREE
MD | | 22c. DATE SIGNED
6-2-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD A. FITZGERALD | | 22e. ADDRESS
217 UNIVERSITY BLVD EAST SILVER SPRING, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
5/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA 20901 | | 24. FUNERAL DIRECTOR
NAME ADDRESS
RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JUN 9 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not, any injury, or other traumatic event, the medical examiner must be notified of one.

00-00000

AND

ALL

MANUFACTURED



Barrett & Foxworth

James C. Foxworth

300 Madison Avenue, New York 17, N.Y.

1960

AMERICAN UNIVERSITY

1960

1960

00-10157

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17891 |
|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ROY F. WILLIAMS III | | | | | | | | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED
June 17 1986 |
| 3. SEX MALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR
DEC 14 1946 6. AGE (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN
39 14 46 39 | | | | | | | | | | 2b. DATE PRONOUNCED DEAD
June 12 1986 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KENTUCKY 7b. CITIZEN OF WHAT COUNTRY?
USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Annapolis MD |
| 10. CITY OR TOWN OF DEATH
Olney 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK)
chief, operations officer 12b. KIND OF BUSINESS OR INDUSTRY
BANKING |
| 13a. STATE
MD 13b. COUNTY
Mont 13c. CITY OR TOWN
BRINKLOW | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS
12801 Pinebark Way 20862 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ROY F. WILLIAMS JR. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
NANCY - PATTERSON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO 16b. SOCIAL SECURITY NO.
215-44-0541 17. INFORMANT
MARTHA H. WILLIAMS | | | | | | | | | | 18. PINEBARK WAY
BRINKLOW, MD. 20862 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<u>None</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
<u>None</u> 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
P.M. 19 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John S. Rogers</u> TITLE (SPECIFY)
M.D. <u>Doft</u> MEDICAL EXAMINER DATE SIGNED <u>June 17 1986</u> | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) DR. JOHN S. ROGERS ADDRESS
SILVER SPRING, MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL 23b. DATE
JUNE 21, 1986 23c. NAME OF CEMETERY OR CREMATORY
LAKE VIEW CEMETERY 23d. LOCATION
CLEVELAND CUYAHOGA OHIO | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 25a. DATE REC'D. BY REGISTRAR
JUN 23 1986 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | | | | | | |

07/84

25M

BP

DHMH - 17
(VR A15 ME (5))

1

RECEIVED FOR THE RECORDS

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C.

00-10969

2
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 9 2

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HAZEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/10/86 | | | 2b. HOUR
8:43p M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAR. 13, 1904 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME- | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3838-ROLAND AVE., 21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES W. GANNON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY JANE NELL | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
217-09-4631A | | | 17. INFORMANT ADDRESS
-REV.DR. REICHARD - NLH-ROCKVILLE, MD. | | | | | | |

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Primary Hepatocellular</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Carcinoma with Metastases</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<i>Large Bowel Obstruction</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>5-27-86</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Bowel Obstruction</i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-18</i> 19 <i>86</i> , to <i>6-10</i> 19 <i>86</i> that (I) (we) last saw the deceased alive on <i>6-10</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Harold F. M'Cann</i> | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>6-11-86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>HAROLD F. M'CANN</i> | | | | 22e. ADDRESS
<i>4362-26th St. N. Arlington Va</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
6-13-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | 23e. DATE REC'D BY REGISTRAR
JUN 11 1986 | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
THE HYSONG CO., 1300-N ST., NW WASH., DC | | | | 25. REGISTRAR'S SIGNATURE
<i>Gina Davidson-Randall</i> | | | | | |



00-098161-

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 9 3

REG. NO.

| | | | | | |
|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILTON GRIFFITH WOOD, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 11 1986 | | 2b. HOUR
P
1:40 |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 30 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 9. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 12. CITY OR TOWN OF DEATH
BETHESDA | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BARBER | | 15. KIND OF BUSINESS OR INDUSTRY
Self-Employed |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
MARYLAND | 16b. COUNTY
ANNE ARUNDEL | 16c. CITY OR TOWN
SEVERN | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 16e. STREET ADDRESS / ZIP CODE
7925 TOWER COURT ROAD 21144 | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
MILTON GRIFFITH WOOD, Sr. | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAUD MAE KINNA | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 20. SOCIAL SECURITY NO.
579-24-2087 | | 21. INFORMANT ADDRESS
DEBBIE MCGRATH, 2308 STARFISH ROAD, APT. 301, | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). ADENOCARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 25a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 25b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 26. I certify that (I) (this hospital) attended the deceased from MAY 30, 19 86, to JUNE 11, 19 86, that (I) (we) last saw the deceased alive on JUNE 11, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) | | | | | |

MEDICAL CERTIFICATION

27a. PHYSICIAN'S NAME (TYPE OR PRINT)

G. A. CALLEJA, LT. MC, USNR

DEGREE

MP

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

27c. DATE SIGNED

12 JUN 86

27b. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 2081428a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

28b. DATE

Jun 14, 1986

28c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

28d. LOCATION
CITY OR TOWN

Brentwood

COUNTY

P.G. Maryland

STATE

29. FUNERAL DIRECTOR

F. Gasch's Sons F.H. P.A. Hyattsville, Maryland

30a. DATE REC'D. BY REGISTRAR

JUN 18 1986

30b. REGISTRAR'S SIGNATURE

John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Revised 1-1-62



Project: Lincoln County, Kentucky
Date: 10/10/60
Location: 1000 N. 1st St., Louisville, Kentucky

00-11093

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 9 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--------|--|---|--|------|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | M | | | | | |
| Jesse B. WOOLWINE | | | June 27, 1986 | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | | |
| Male | | White | | MONTH DAY YEAR | | 65 YRS. | | MONTHS DAYS HOURS MIN. | | | |
| March 3, 1921 | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| Virginia | | USA | | Damascus | | | | 26700 Haney Ave. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Machine Operator | | | | Parks | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Montgomery | | Damascus | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 26700 Haney Ave., 20872 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | 16b. SOCIAL SECURITY NO. | | | | | |
| Henry Lacie Woolwine | | | Lena Ada Linkous | | | 224-24-9305 | | | | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Ruth B. Woolwine, Item 13 | | | | | | ASCVD | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE KINDS OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost the deceased on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE Charles W. Karesch DEGREE | | | | | | | | | | 6/27/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RARESEIT | | | | | | | | | | 22e. ADDRESS 15 E. Deer Park Dr., Gaithersburg, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | June 30, 1986 | | | Mount Olivet | | | Frederick, Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Olin L. Molesworth, P.A., Damascus, Md. | | | | | | JUL 1 - 1986 | | | June Molesworth | | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's office is notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

60-11003

June 27, 1968

WOOLMOUTH

H. Jesse

Male

White

March 3, 1951

02

x

Montgomery County,

USA

Virginia

26700 Haney Ave.

Danvers

Machine Operator Parks

26700 Haney Ave., 20872

x

Danvers

Montgomery

Maryland

Danvers

Ada

Idaho

Woolfene

Lacle

Henry

Item 13

Ruth F. Woolfene,

224-24-9302

No

12 E. Deer Park Dr., Jaffersburg, Md.

Friedrick, Maryland

Mount Olive

June 30, 1968

Serial

Olga I. Moleworth, P.A., Danvers, Md.

00-10223

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17395
REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CONSTANCE PENDLETON YEOMANS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JUNE 12 1986 | | 2b. HOUR
5:04 P M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 23 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |

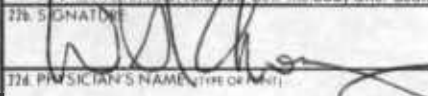
| | | | | | | |
|--|---|---|--|---------------------------------------|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | | 13b. COUNTY
ARLINGTON | 13c. CITY OR TOWN
ARLINGTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4520 S. 31st STREET 22206 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP PENDLETON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHARLOTTE REID | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
227-54-1740 | 17. INFORMANT ADDRESS
REID PENDLETON, 404 S. 12th STREET, | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,
(b) CARDIAC ARRYTHMIA | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **JUNE 4 1986** to **JUNE 12 1986** that (I) (we) last saw the deceased alive on **JUNE 12 1986** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|---|---------------------------------------|
| 22b. SIGNATURE
 | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
13 June 86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W.R. THOMPSON, LT. MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
6/14/86 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, MD |
|---|-----------------------------|---|---|

| | | |
|--|---|---|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | 25a. DATE REC'D. BY REGISTRAR
JUN 18 1986 | 25b. REGISTRAR'S SIGNATURE
 |
|--|---|---|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2130 Macomb Ave, N, Washington, D.C. 20016
Joseph Gawler's Sons, Inc.
Brentwood 6/24/86 Cedar Hill Crematory
Baltimore, MD

00-10843

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8617890

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CATHERINE WHEATLEY YOUNG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
June 23, 1986 | | 2b. HOUR
7:30 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8-26-24 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Claude Wheatley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Lyda Collins | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-16-6633 | 17. INFORMANT
ADDRESS
Ronald J. Young Son Same As 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Laennec's cirrhosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Approximate interval between onset and death
6 months
15 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Diabetes mellitus, Cardiomyopathy, pneumonitis | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 22 , 19 86 , to June 23 , 19 86 , that (I) (we) last saw the deceased alive on June 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Arthur S. Bresler, M.D. | | | DEGREE
M.D. | | 22c. DATE SIGNED
6/23/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur S. Bresler M.D. | | | 22e. ADDRESS
10881 Lockwood Drive Silver Spring, Md. 20901 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 26, 86 | 23c. NAME OF CEMETERY OR CREMATORY
Denton Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Denton Caroline Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins, Jr.
500 University Blvd. West Silver Spring, Md. | | | 25a. DATE REC'D BY REGISTRAR
JUN 30 1986 | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

92

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

11-11-11

(1)

RECEIVED
IN THE
OFFICE OF THE
SHERIFF
OF THE
COUNTY OF
SANTA BARBARA
CALIFORNIA
JAN 11 1911
BY
SHERIFF
J. H. BROWN
CLERK

Warrant for the arrest of

X

Jan 11 1911

John Doe

County of Santa Barbara

11/11/11

①

00-09-138

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17893

| | | | | | | | |
|--|--------------------------|--|---|---|---|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) <i>Aspasia</i> MIDDLE <i>K</i> LAST <i>Zaimes</i> | | 2b. DATE KNOWN OF DEATH ESTI-MATED <i>June 8 1986</i> | | 2c. DATE PRONOUNCED DEAD <i>June 8 1986</i> | |
| 3. SEX <i>Female</i> | 4. RACE <i>Caucasian</i> | 5. DATE OF BIRTH MONTH <i>12</i> DAY <i>22</i> YEAR <i>1923</i> | 6. AGE (IN YEARS) LAST BIRTHDAY <i>63</i> RS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Greece</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY <i>Silver Spring</i> | | 13d. STREET ADDRESS <i>818 Rowen Road 20910</i> | |
| 14. FATHER'S NAME FIRST <i>Constantine</i> MIDDLE LAST <i>Kontaxis</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Anastasia</i> MIDDLE LAST <i>Janes</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>577-18-3765</i> | | 17. INFORMANT ADDRESS <i>Constance Cokas Daughter Same as 13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular dis</i>
DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>CORD and Atherosclerosis</i>
(c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fract. Rt. Hip</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>5-13-86</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fract. Rt. Hip</i> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 5 1986</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell at home</i> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | 21f. LOCATION STREET <i>Rowen Rd</i> CITY OR TOWN <i>Silver Spring</i> COUNTY <i>Montgomery</i> STATE <i>Md</i> | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | TITLE (SPECIFY) <i>M.D. Prof.</i> | | MEDICAL EXAMINER | | DATE SIGNED <i>June 8 1986</i> | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>June 10, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i> | | 23d. LOCATION CITY OR TOWN <i>Washington D.C.</i> COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i> ADDRESS <i>500 University Blvd. West Silver Spring, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

00-000000

2000-01-10



RECEIVED

2000-01-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 8 9 9
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) IRWIN JACK Zimberg | | | 2a. DATE OF DEATH
MONTH DAY YEAR
6/22/86 | | 2b. HOUR
5:18 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 15, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Furnishings | |

| | | | | | | |
|---|--|--|---|---|---|--|
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5225 Pooks Hill Rd., Apt. 911 N 20817 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Zimberg | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Siletsky | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW 2 | | 16b. SOCIAL SECURITY NO.
051-07-7089 | | 17. INFORMANT
Alan L. Zimberg | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 hours |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Extensive Anteroseptal Myocardial Infarction | | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary artery disease | | 10 yrs |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Ventricular Tachycardia

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **6/20**, 19 **86**, to **6/22**, 19 **86**, that (I) (we) last saw the deceased alive on **6/22**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|-----------------------|--|------------------------------------|
| 22b. SIGNATURE
MARTIN S. KANASKY | DEGREE
M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
6/22/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN S. KANASKY | | 22e. ADDRESS
5401 Western Ave NW, Washington DC 20015 | |

| | | | |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
6/24/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Beth David Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elmont, L. I. New York |
|--|-------------------------------|--|---|

24. DONOR OF ORGAN: **STEIN HEBREW MEMORIAL FUNERAL HOME**
232 CARROLL STREET, N.W., WASHINGTON, D. C.
25a. DATE REC'D. BY REGISTRAR: **JUN 25 1986**
25b. REGISTRAR'S SIGNATURE: **Julia F...**

0-11054



BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, state any injury, or other traumatic event, or medicolegal matter, in the notation at the bottom of the certificate.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|---|--|--------------------------------|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Eva Zorn | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
6 - 8 - 86 | | | | | 2b. HOUR
9:30p M | |
| 3. SEX
FEMALE
WHITE | | 4. RACE
white
FEMALE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC. 28, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Finland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oskar ---- SUNDBALL | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
OLGA ---- SUNDBALL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-40-1237 | | 17. INFORMANT
ADDRESS
REV. DR. REICHARD-N.L.H.-ROCKVILLE, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>5 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Mitral Valve Prolapse</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> , 19 <u>86</u> , to <u>June 8</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>June 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold F. McCann</u> | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
6-9-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | | | 22e. ADDRESS
4362-20th St. N. Arlington, Va. 22207 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
6-12-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HYSONG CO., INC. - 1300 N ST., NW WASH., DC | | | | 25. DATE REC'D. BY REGISTRAR
JUN 17 1986 | | | | 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

0-00000-0

ADDITIONAL

FOR COPIES

MINUTE

